

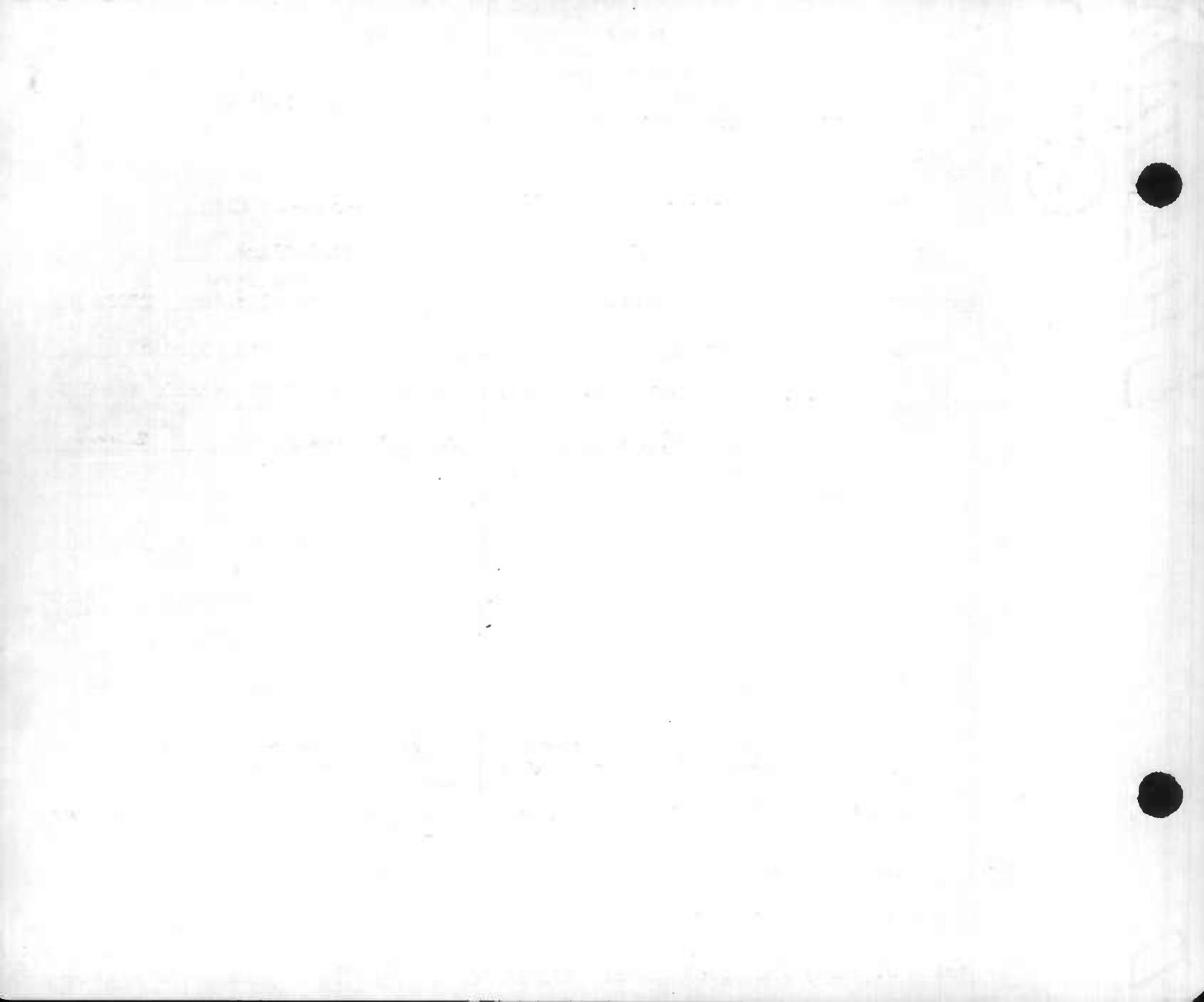
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 4 16280													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Mr. Theodore R. Showacre						June 16, 1984							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		white		May 14, 1920			64			MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.					Baltimore City						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore		2922 Rosalie Ave		Postal Clerk									
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Baltimore					2922 Rosalie Ave 21234						
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			ADDRESS						
George		Showacre		Gertrude			Von Nordick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS						
Yes		W.W.11		219-05-0551			Mrs. Santa Showacre 2922 Rosalie Ave 21234						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the pancreas</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF 2 mos													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>84</i> , to <i>June</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>June</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Arthur Serpick</i>		DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/19/84</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Arthur Serpick		7620 York Rd.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/84		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cem.			23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc		ADDRESS 5305 Harford Rd. 21214		25a. DATE REC'D. BY REGISTRAR 11/20/1984			25b. REGISTRAR'S SIGNATURE <i>Via Davidson-Pendell</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

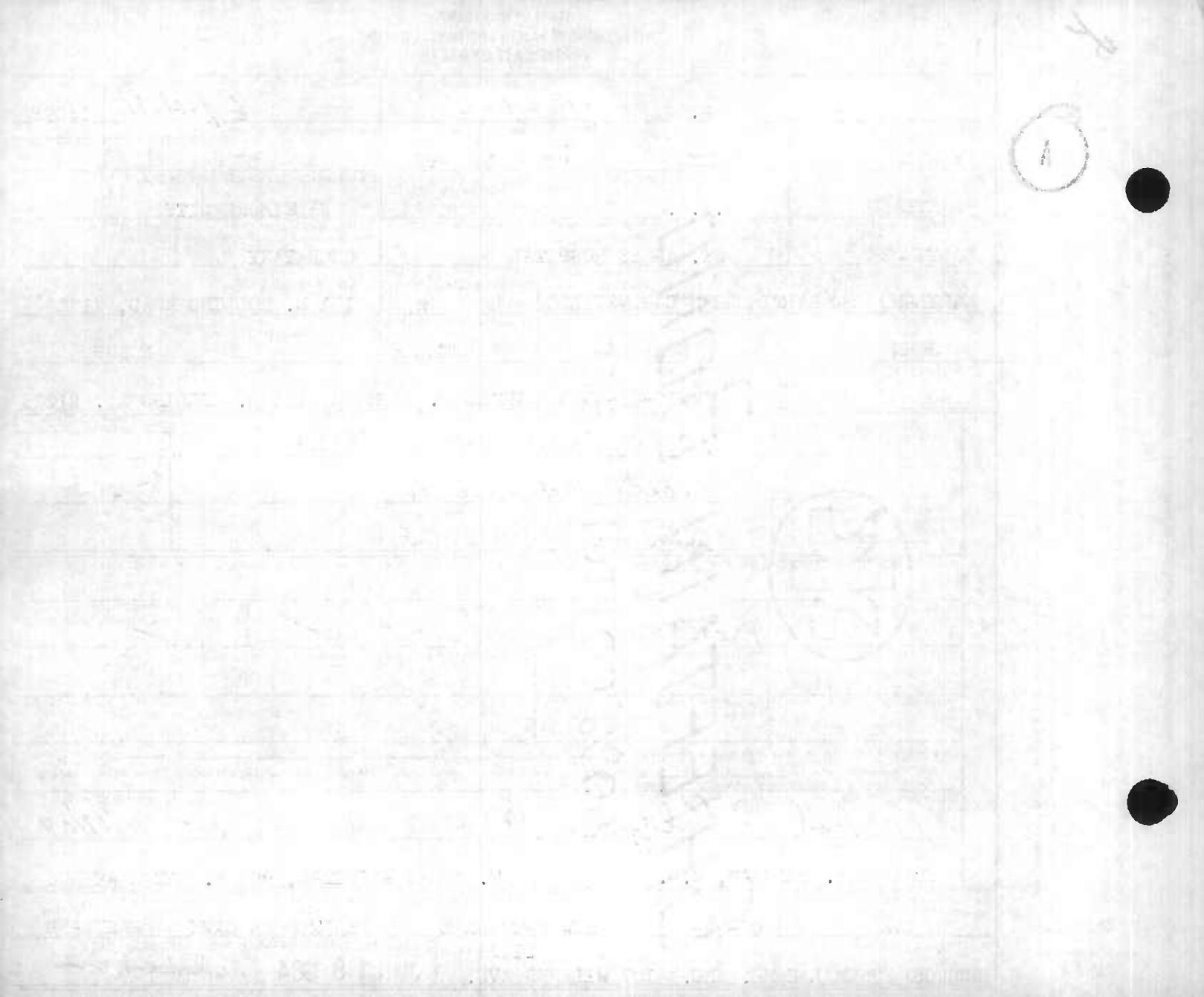
IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4 1 6 2 8 9

1. DECEASED NAME (TYPE OR PRINT)			FIRST ETHEL	MIDDLE N.	LAST SIGWALD	2a. DATE OF DEATH MONTH 6/16/84	DAY YEAR 6/16/84	2b. HOUR 2:09 P.M.				
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH MONTH 02			DAY 14	YEAR 97	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS 87	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY				
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 101 N. ROLLING ROAD, 21228		12b. KIND OF BUSINESS OR INDUSTRY HOBBS		
14. FATHER'S NAME FIRST JOHN		MIDDLE 	LAST NORFOLK	15. MOTHER'S MAIDEN NAME FIRST ESTELLE			MIDDLE 	LAST 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-03-4305			17. INFORMANT HELEN P. SIGWALD			ADDRESS 101 N. ROLLING RD, 21228				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5860												
DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOPNEUMONIA												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) RENAL FAILURE												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED DUODENAL ULCER			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Michael E. Pelczar		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/>		22e. MEDICAL DIRECTOR <input type="checkbox"/>		22f. STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED 6/17/84	
22a. PHYSICIAN'S NAME (TYPE OR PRINT)					22d. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-20-84		23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL			23d. LOCATION CITY OR TOWN BALTIMORE CITY		COUNTY	STATE MARYLAND		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR JUN 18 1984		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall					



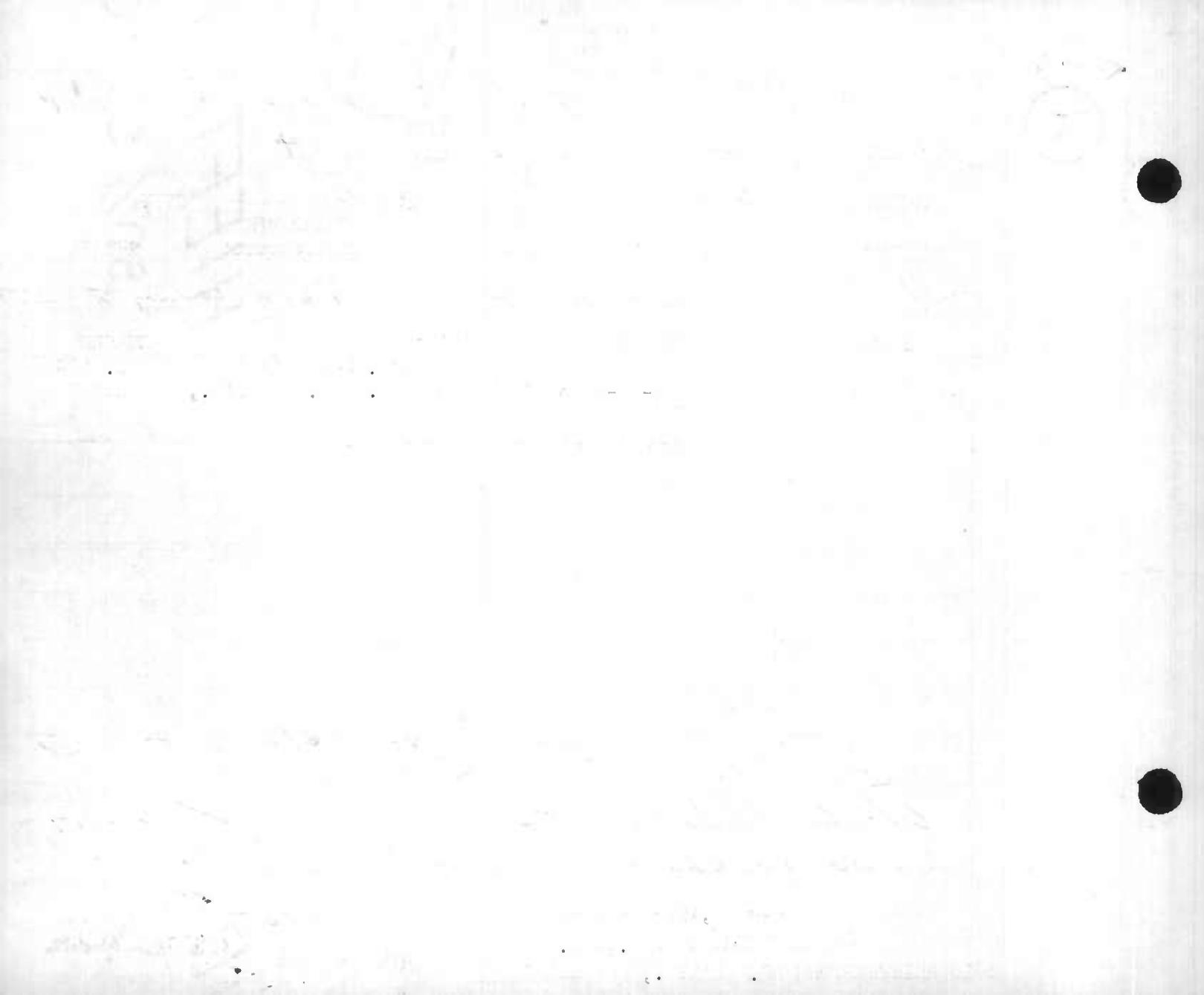
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 4 1 6 2 9 0											
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST MAURICE		MIDDLE	LAST SILBERT	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
		<i>Maurice</i>						<i>Silbert</i>	<i>6/6/84</i>					<i>1:15 PM</i>							
3. SEX		4. RACE		5. DATE OF BIRTH		1912		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
<i>M ALE</i>		<i>White</i>		MONTH <i>6</i>		DAY <i>6</i>		YEAR <i>XXXX</i>		MONTHS <i>72</i>		DAYS <i>XX</i>		HOURS YRS.							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH																	
<i>MARYLAND</i>		<i>U. S.</i>		MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		<i>Baltimore</i>		CITY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)																	
<i>Baltimore</i>		<i>South Baltimore Conv. Hosp</i>		<i>MERCHANT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RETAIL</i>															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE													
<i>Maryland</i>				<i>Baltimore</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<i>1 WEST Conway St</i>		21201											
14. FATHER'S NAME		FIRST MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT											
		<i>LOUIS</i>		<i>SILBERT</i>		<i>RACHAEL</i>		<i>212-20-9813</i>		<i>MRS. REBECCA GOLDNER</i>		APT. 106									
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
<i>NO</i>				<i>212-20-9813</i>				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer - Pulmonary Artery</i>													
5140		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Artery</i>																	
				DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) <i>this hospital</i> attended the deceased from <i>5/8/84</i> 19 <i>84</i> to <i>6/6</i> 19 <i>84</i> , that (I) <i>we</i> last saw the deceased alive on <i>6/6</i> 19 <i>84</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>we</i> (did) (did not) view the body after death.																					
22b. SIGNATURE <i>Walter Lockhart, MD</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>6/6/84</i>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Walter Lockhart</i>		22e. ADDRESS <i>3001 S. Hanover St</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>JUNE 8, 1984</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>CHIZUK AMUNO</i>		23d. LOCATION CITY OR TOWN <i>BALTIMORE</i>		COUNTY		STATE <i>MARYLAND</i>											
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 14 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Jeha Levinson</i>																	
6010 REISTERSTOWN RD. BALTO., MD 21215																					

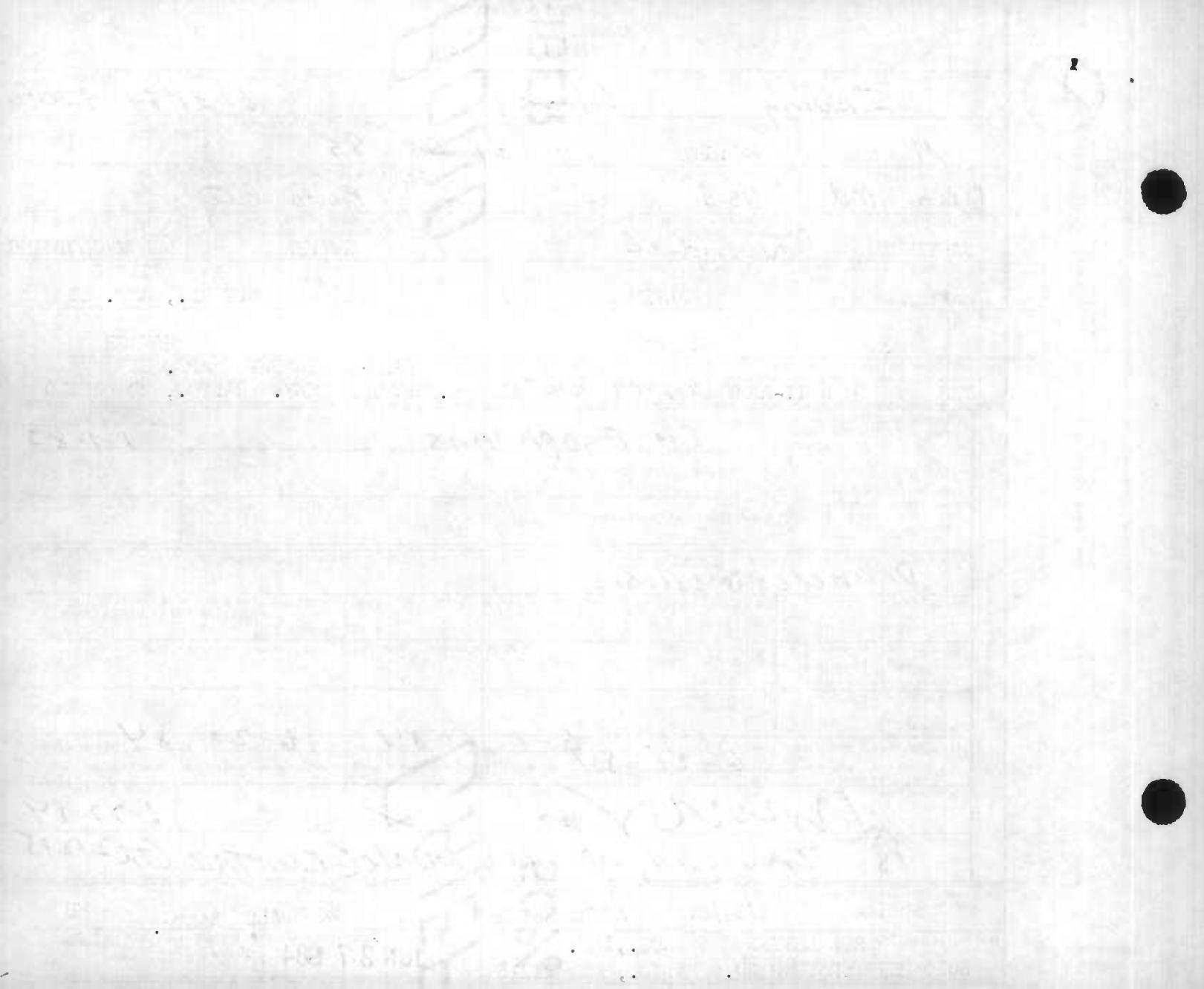


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 4 1 6 2 9 1					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
<i>Irving</i>							<i>Silesky</i>		6/21/84					9:30 AM	
3 SEX		4. RACE		5. DATE OF BIRTH		MONTH		DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M ALE		W HITE		9 29 1898		85		YRS.		MONTHS		YEARS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		XX		9 BALTIMORE CITY OR COUNTY OF DEATH		BALTIMORE CITY		MD.			
BALTO MD		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13e. STREET ADDRESS / ZIP CODE		#21215					
BALTIMORE		Feverndale		CUTTER		LEBOW CLOTHING		3110 BANCROFT RD., APT. 1B							
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		#21215					
14. FATHER'S NAME MAX		MIDDLE		LAST SILESKY		15. MOTHER'S MAIDEN NAME ANNA		16. SOCIAL SECURITY NO. 216-09-9645		17. INFORMANT DANIEL SILESKY APT. 227		LAST SAVAGE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. (IF YES, GIVE WAR OR DATES) WWII - ARMY		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-1-83		16d. SOCIAL SECURITY NO.		16e. PLACE OF INJURY 190 W. NORTHERN PKWY. BALTO., MD 21210		16f. INFORMANT DANIEL SILESKY APT. 227		16g. LAST NAME SAVAGE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18b. DUE TO, OR AS A CONSEQUENCE OF (b)		18c. DUE TO, OR AS A CONSEQUENCE OF (c)		18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-1-83									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>6-21-84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Dr. Levinson</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 6-22-84									
22f. PHYSICIAN IN CHARGE (TYPE OR PRINT) SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215		22g. ADDRESS Levinson & Bros., Inc. 6010 Reisterstown Rd., MD 21215		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/24/84		23c. NAME OF CEMETERY OR CREMATORIUM ANSHE NEISEN		23d. LOCATION CITY OR TOWN ROSEDALE		COUNTY BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JUN 27 1984		25b. REGISTRAR'S SIGNATURE <i>Levinson & Bros., Inc.</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with a checkmark, then all injury, or other traumatic event, the medical examiner must be called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
4 16292											REG. NO.						
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			2b. HOUR					
Maurice			Silver						6-4-84			6:35 PM					
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>11-01-1909</i>			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE - STATE OR FOREIGN <i>Pennsylvania</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>			MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lewinsale</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>OWNER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>TAXI CABS</i>								
13a. STATE <i>MARYLAND</i>			13b. COUNTY			13c. CITY OR TOWN <i>BALTIMORE</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>3010 FALLSTAFF RD. APT. D21209</i>					
14. FATHER'S NAME FIRST <i>ROBERT</i>			MIDDLE			LAST <i>SILVER</i>			15. MOTHER'S MAIDEN NAME FIRST <i>ROSE</i>			MIDDLE			LAST <i>SILVER</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>214-03-0095</i>			17. INFORMANT ADDRESS <i>MRS. SYLVIA SILVER 3010 FALLSTAFF RD. 21209</i>			APT. D								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>5250</i>			IMMEDIATE CAUSE (a) <i>CHRONIC RENAL FAILURE</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-84</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5-21</i> , 19 <i>84</i> , to <i>6-4</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>6-4</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>A. Silver</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6-5-84</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. Levinson</i>			22e. ADDRESS <i>6801 Belair Rd Levinstone Ctr Baltimore MD 21215</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>6/5/84</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>BETH EL MEMORIAL PARK RANDALLSTOWN BALTIMORE</i>			23d. LOCATION CITY OR TOWN <i>MARYLAND</i>			COUNTY			STATE		
24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i>			ADDRESS <i>6010 REISTERSTOWN RD BALTIMORE, MARYLAND 21215</i>			25a. DATE RECEIVED BY REGISTRAR <i>JUN 6 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Julie Levinson-Randall</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and completely filled in by the funeral director. Please sign page 3 and 2 should be filed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers (page 3 and 2 should be filed within 24 hours) and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it is mandatory to complete the medical certification section.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20 DATE OF DEATH	MONTH	DAY	YEAR	20b. HOUR
ALBERT C. SILVIA						JUNE 25, 1984				2:20A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR May 8 1919		65 YRS.			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) R.I.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab.			12b. KIND OF BUSINESS OR INDUSTRY Chemical			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 140 N. Linwood Ave. 21224		
14. FATHER'S NAME FIRST Anton Silvia		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Unknown		MIDDLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 039-05-5324		17. INFORMANT		ADDRESS J. Silvia 140 N. Linwood Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1:45 AM - 2:20 AM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Brain Death								
(c)		DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/10, 1984, to 6/25, 1984, that (I) (we) last saw the deceased alive on 6/25, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James E. Greenwald MD PhD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/25/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. GREENWALD		22e. ADDRESS Johns Hopkins Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-28-84		23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN Baltimore		COUNTY	STATE Md.	
24. FUNERAL DIRECTOR B. Dabrowski & Son 2818 E. Balto. St.		ADDRESS NAME		25a. DATE REC'D. BY REG. CLERK JUN 28 1984		25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16294			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 6-6-84							2b. HOUR 8:02 P.M.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Alfonzo W. Simmons						6-6-84				8:02 P.M.			
3. SEX MALE			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 12-23-11			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD.				
10. CITY OR TOWN OF DEATH BALT.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALT			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD			13b. COUNTY CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 915 CHAUNCEY AVE 21217				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 240-07-3210			17. INFORMANT Michael R. Simmons 915 Chauncey Ave.			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(b) RENAL FAILURE { DUE TO, OR AS A CONSEQUENCE OF (c) PROSTATE CANCER { DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION 5-24-84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UREMIA PERCUTANEOUS Nephrostomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5-20 1984 to 6-6-1984, that (I) (we) last saw the deceased alive on 6-6-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE CHARLES SCHWARTZ, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6-6-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES SCHWARTZ, M.D.			22e. ADDRESS SINAI HOSPITAL BALTIMORE MD										
23a. BURIAL, CREMATION, REMOVAL CREMATION			23b. DATE 6/9/84			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Pk.			23d. LOCATION CITY OR TOWN Catonsville, COUNTY Md. STATE				
24. FUNERAL DIRECTOR Wm C March F/H Inc., 1101 E North Avenue						25a. DATE REC'D. BY REGISTRAR JUN 8 1984			REGISTRAR'S SIGNATURE Julia Schwartz-Penwell				

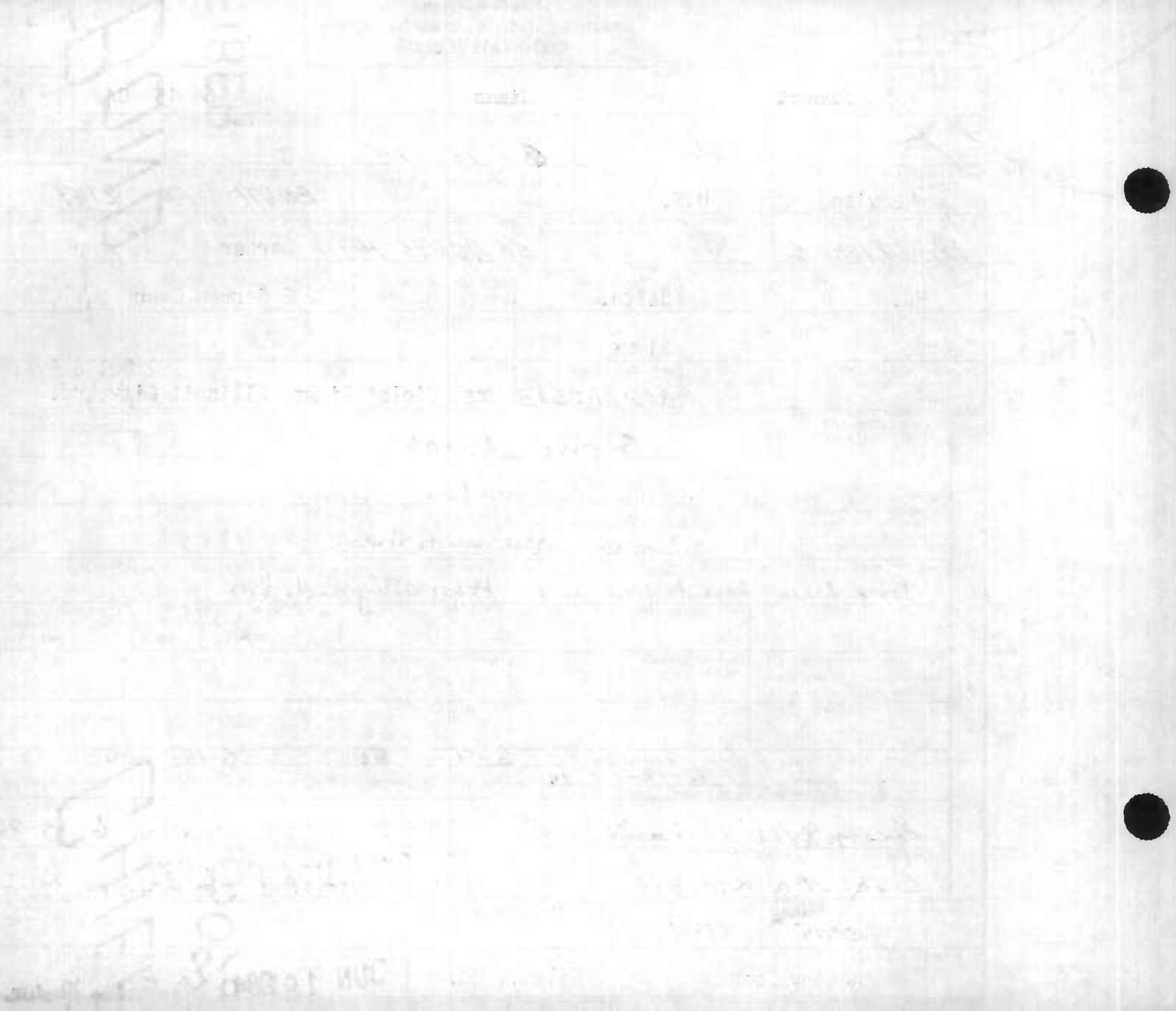
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 23 shows any injury, or other traumatic event, the medical certifier must be notified and the cause of death must be re-assessed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3 4 1 6 2 9 5	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 12 A.M.	
			Ernest			Simms			6 13 84			45	
3. SEX <i>m</i>			4. RACE <i>m</i>			5. DATE OF BIRTH MONTH DAY YEAR 7 13 1901			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber			12b. KIND OF BUSINESS OR INDUSTRY Shop				
13a. STATE Md.			13b. COUNTY Balto.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3236 Gorham Court 21227				
14. FATHER'S NAME George			LAST Simms			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-01-0683			17. INFORMANT Mrs. Violet Simms			ADDRESS 752 Delta Ave. Ellicott City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>E. coli negative sepsis</i> . DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe malnutrition</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Congestive heart failure Hypothyroidism</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>6-9-1984</i> to <i>6-13-1984</i> , that (I) (we) lost saw the deceased alive on <i>6-13-1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>G. Vellani Karan</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6-13-84</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. VELLANI KARAN</i>			22e. ADDRESS St. Agnes Hospital 900 S. Caton Ave. Baltimore MD 21229										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 6/13/84			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 19 1984			25b. REGISTRAR'S SIGNATURE <i>Lillian K. Johnson</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 months of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, no medical examiner may be retained at the scene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6296	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Elma SIMPSON			Elizabeth ELMA			Simpson E		8 - 90 84		4:35 A.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			67 YRS.		IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY own home				
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 304 E. Broadway 21791			
14. FATHER'S NAME FIRST Charles		MIDDLE Edgar		LAST Lambert		15. MOTHER'S MAIDEN NAME FIRST Laura		MIDDLE Luvinia		LAST Beall	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT G. Blair Simpson		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4589 DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIC SHOCK HYPOTENSION 24 HRS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		ADDRESS 304 E. Braodway		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
						(c) SEPTIC SHOCK, MENINGITIS 1 WEEK					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
ADULT RESPIRATORY DISTRESS SYNDROME ACUTE RENAL FAILURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JUNE 4 1984 to JUNE 10 1984 , that (I) (we) last saw the deceased alive on JUNE 10 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Robert V. Zawodny		22c. DEGREE MD		22d. DATE SIGNED 6/10/84							
22e. ADDRESS Dept. of Medicine U. of Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/84		23c. NAME OF CEMETERY OR CREMATORIALY Mt. View Cemetery		23d. LOCATION CITY OR TOWN Union Bridge Carroll MD					
24. FUNERAL DIRECTOR NAME D. D. Smith Jr.		ADDRESS McWhinney, Md.		25a. DATE REC'D. BY REGISTRAR JUN 12 1984		25b. REGISTRAR'S SIGNATURE lia Sawdon-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use at the burial/tranquillization. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death.

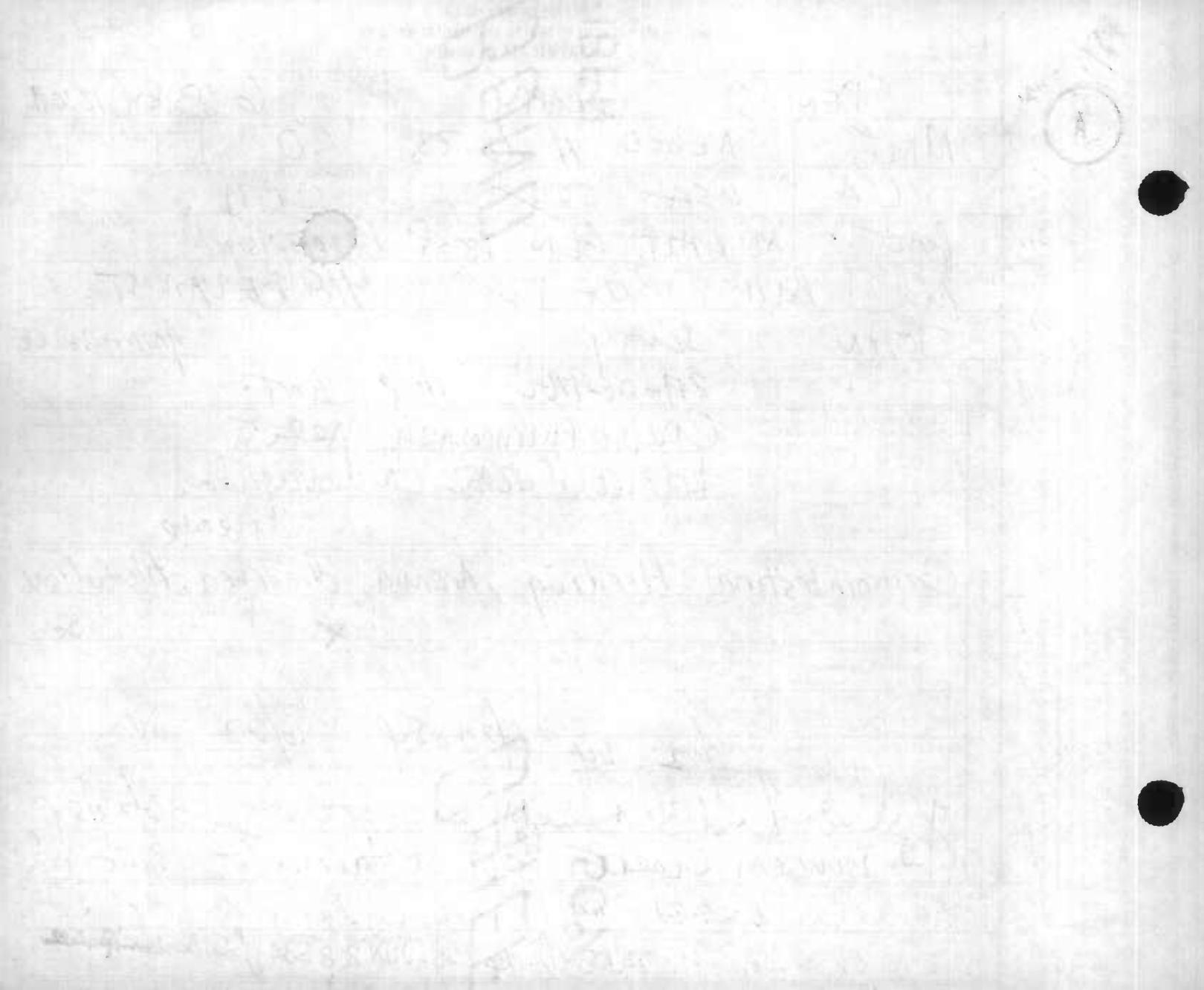
IMPORTANCE: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3416291

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
DENNIS					SLAPPY	6 23 84				1230 P.M.	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (INCLUDE LAST BIRTHDAY)	7. UNDER 1 YEAR		8. UNDER 24 HRS			
Male		Negro	11 6 38		50	YEARS	MONTHS	WEEKS	HOURS	MIN.	
7b. BIRTHPLACE (NAME OF FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.					
BACT.		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH A MANNER AS STREET ADDRESS)		12. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE		13. KIND OF BUSINESS OR INDUSTRY					
BACT.		SO BART. GEN Hosp.		Unemployed							
10a. STATE		10b. COUNTY		10c. CITY OR TOWN		11. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS, ZIP CODE 918 BEVAN ST 21230			
Md		BART		BACT							
14. FATHER'S NAME		MIDDLE	15. MOTHER'S MOTHER'S MAIDEN NAME		16. ANNABELLE						
John			Scappy								
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
(IF YES, GIVE WAR OR DATES)		PA-28-9162		Hosp. Chrt.							
18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CHRONIC PULMONARY ARREST											
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Gastrintestinal bleeding, Anemia, diarrhea, Alcoholism											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/20/84 to 6/23/84, and that (I) (we) lost saw the deceased alive on 6/20/84, (I) (we) did not view the body after death,		22b. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dowdousas Clarke		22e. ADDRESS 80 Hanover St., BACT. Md.									
23a. BURIAL, CREMATION, REMOVAL ISPECI		23b. DATE 6-29-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Bur. Co.		23d. LOCATION CITY OR TOWN		COUNTY			STATE
Burial								Md.			
24. FUNERAL DIRECTOR NAME Brown - Thompson FH.		ADDRESS 7913 W. Balt St.		25a. DATE RECEIVED BY REGISTRAR JUN 28 1984		25b. REGISTRAR'S SIGNATURE John D. Dowdousas Clarke					



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

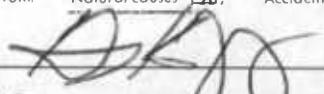
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										6 298			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
ANNE C. SLATER						6 4 84						4:30 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Female			White			MONTH DAY YEAR Mar. 22, 1900			84			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8b. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Good Samaritan Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY State Gov't.				
13a. STATE MD			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1527 E. Northern Pkwy. 21239	
14. FATHER'S NAME First: Edwin			MIDDLE: F.	LAST: Knokey	15. MOTHER'S MAIDEN NAME First: Mary			Middle: Parker			Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220 36 0113			17. INFORMANT			ADDRESS Rev. E. David Slater, Balto., MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RE. C.V.A.</u> 4360										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 MONTHS			
DUE TO, OR AS A CONSEQUENCE OF, (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> 19 <u>84</u> , to <u>6/14</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6/14</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Edwin Yeo</u>										DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 6/4/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EDWIN YEO</u>										22e. ADDRESS GOOD SAMARITAN HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/8/84			23c. NAME OF CEMETERY OR CREMATORIAL Green Mount			23d. LOCATION CITY OR TOWN Balto., COUNTY MD STATE				
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road			25a. DATE REC'D. BY REGISTRAR JUN 5 1984			25b. REGISTRAR'S SIGNATURE <u>Julie Davidson Pendell</u>							

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6299

REG. NO.

1-
FOR
STATE
REGISTRAR

I. DECEASED NAME FIRST MIDDLE LAST					2a DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR	2b. HOUR
Rea B. Slusky					6/11/84 19	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	12b. HOUR
FEMALE	WHITE	JAN. 7, 1905	79 yrs		6/11/84 19	12:44 P M
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b CITIZEN OF WHAT COUNTRY? USA		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) 3501 St. Paul St., Apt. 1025			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	
12b. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3501 ST. PAUL ST. #21218	12b. KIND OF BUSINESS OR INDUSTRY MET.LIFE.INS
14. FATHER'S NAME FIRST SOLOMON		MIDDLE	LAST BERNSTEIN	15. MOTHER'S MAIDEN NAME FIRST JENNIE MIDDLE ZELDA LAST BUDKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT BRIAN S. GOODMAN 3RD FL. 20 S. CHARLES ST. BALTO., MD 21201		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE 						
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						
DATE SIGNED 6/12/84						
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 13, 1984		23c. NAME OF CEMETERY OR CREMATORIAL CHIZUK AMUNO		23d. LOCATION CITY OR TOWN BALTIMORE
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BRO., INC.		ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JUN 15 1984		25b. REGISTRAR'S SIGNATURE 



100-8716

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after being retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 3 4 6 3 0 0	
1 - FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Harry	MIDDLE Lawrence	LAST Small		2a. DATE OF DEATH MONTH DAY YEAR 3 4 JUN 18, 1984	
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 23 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2915 Rueckart Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Finance Dept.		
13. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2915 Rueckart Ave. 21214		
14. FATHER'S NAME FIRST Sylvester		MIDDLE Small	LAST	15. MOTHER'S MAIDEN NAME FIRST Emma	MIDDLE	LAST Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW11 215-18-2068		17. INFORMANT Helen Rose Small	ADDRESS 2915 Rueckart Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic cancer, carcinomatosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Colon Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 4/8/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED colon cancer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/8 , 19 83 , to 6/18 , 19 83 , that (I) (we) last saw the deceased alive on 12/15 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert E Martin MD</i>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	21. DATE SIGNED 6/19/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Martin, M.D.		22e. ADDRESS 3201 North Charles Street Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-22-84	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	23d. LOCATION CITY OR TOWN Baltimore	23e. COUNTY	23f. STATE Md.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 20 1984					
		25b. REGISTRATION NUMBER 1					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 6301	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ADA ADA			F.		Small (SMALL)	June 10, 1984			6	10	84	12 12:11 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		black		MONTH	DAY	YEAR	68			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY, MD.			
S. Carolina		U. S. A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore		Church Home Hospital											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland				Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			201 N. Washington St. 21231			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
		Manzie		Ford				Mary	Jane	Smalls			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
NO		249-08-8460		Georganna McFadden			1724 N. Bambrey St						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that at this hospital deceased from on June 10, 1984, to June 10, 1984, that <input checked="" type="checkbox"/> we last saw the deceased alive on on June 10, 1984, and that in <input checked="" type="checkbox"/> our opinion death occurred on the date and hour and from the causes stated above. No one else did not view the body after death.												22c. DATE SIGNED 6/10/84	
22b. SIGNATURE <i>Lawrence J. Appel</i>		DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/10/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence J. Appel M.D.		22e. ADDRESS Church Home Hospital			100 N Broadway			Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Mount Auburn Cem.			23d. LOCATION CITY OR TOWN Baltimore		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendee						
				JUN 11 1984									

20%

COTTON

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be left within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 4 16302						
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Baby Girl Smith						6 22 1984			6 22 84 7:44 AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Black			6 22 1984			YRS. MONTHS DAYS			0 0 0		44		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Baltimore City MD.				
Maryland			USA													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore			MERCY HOSPITAL			Infant										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS (Mother's address)				
MD			QA			Queenstown						Rt 1, Box 226 A. 21658.				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
Roi Clinton Daniels			Theresa Johnson													
18 CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
7650 Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause 1st. (b) <u>severe prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22 7AM 19 84</u> to <u>6/22 7:44 AM 19 84</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Dae Hoon Lee</u>			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <u>8/22/84</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dae Hoon Lee</u>			22e. ADDRESS <u>301 St Paul Pl. Balt. MD.</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 6/28/84			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME Anatomy Board			25a. DATE REC'D. BY REGISTRAR 2 1984			25b. REGISTRAR'S SIGNATURE <u>John K. Johnson, Rendell</u>										

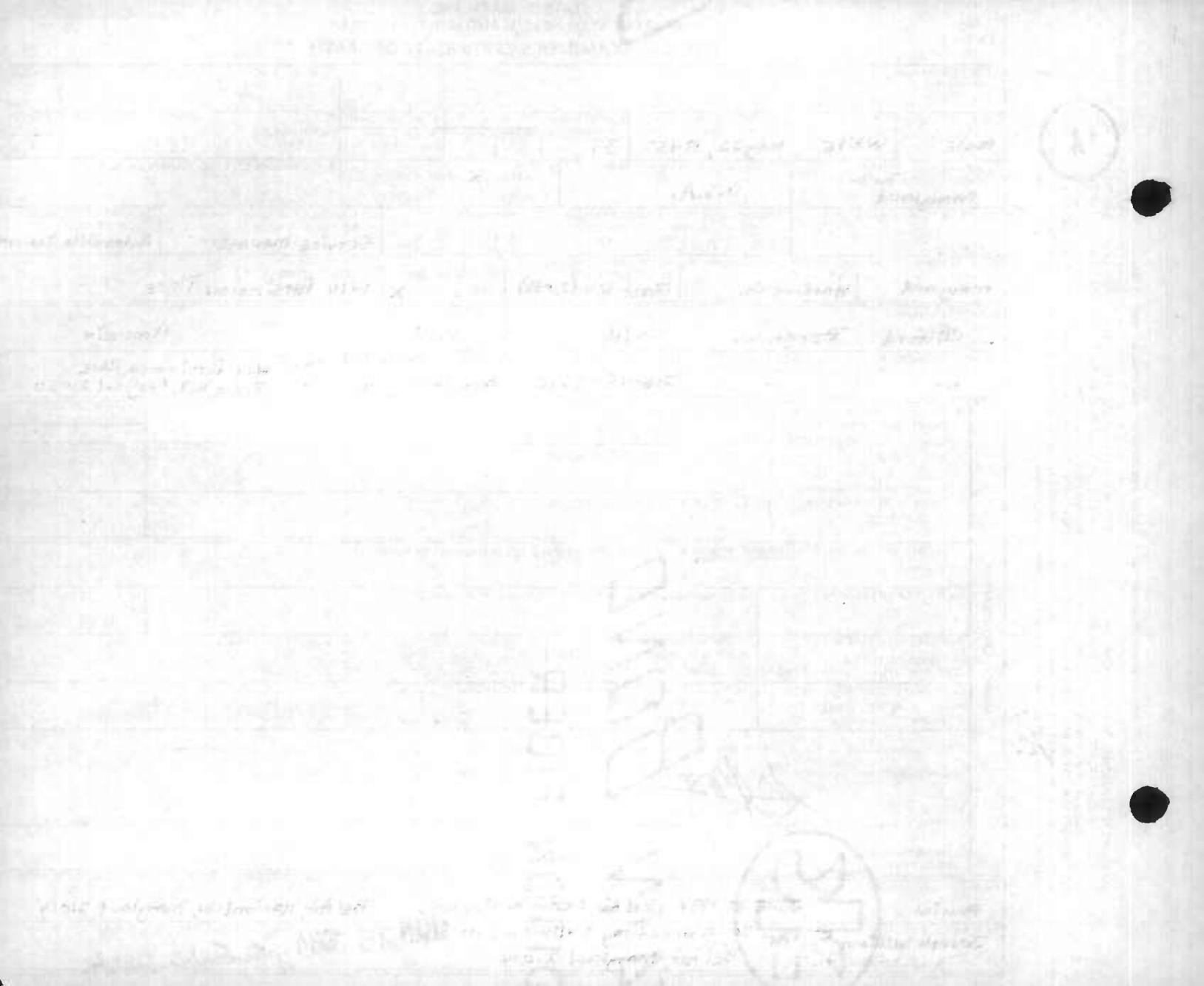


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SODIUM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAM. RETAIN PAGE 5 FOR YOUR FILE. PAGE 2 SHOULD BE FORWARDED TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6303			
1 - STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6/20/84 19									2b. HOUR 12:18 PM			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Clifford			MIDDLE Bergman			LAST Smith, Jr.						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH May 22, 1945		YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 6/20/84 19			
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital Shock Trauma Service Manager									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Automobile dealer			
13a. STATE Maryland			13b. COUNTY Harford Co.			13c. CITY OR TOWN Forest Hill (21050)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1414 Persimmon Place 21050			
14. FATHER'S NAME FIRST Clifford			MIDDLE Bergman			LAST Smith			15. MOTHER'S MAIDEN NAME FIRST Ruth			MIDDLE LAST Amreich			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-48-3690			17. INFORMANT (WIFE) 838-4625 ADDRESS Mrs. Cherry A. Smith Forest Hill, Maryland 21050			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9190 Multiple Injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									2d. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:38x 6/20/84,			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject operator of back hoe that rolled over on top of him									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) worksite			21f. LOCATION STREET Bel Air Datson, 1506 Belair Rd., Harford Co., Md.			CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Gregory R. Kauffman, M.D. M.D. Assistant MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE JUNE 22, 1984			23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014			COUNTY STATE			
24. FUNERAL DIRECTOR Joseph William Foster			ADDRESS 50 W. Broadway & Williams St.			REG'D. BY REGISTRAR 25 184			25. REGISTRAR'S SIGNATURE Julie Devlin, Esq.						
(VR A15 ME (5))															
20M 4/B2															
DHMH - 17															



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 4 1 6 3 0 4

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST ELSIE	MIDDLE J	LAST SMITH	2a. DATE OF DEATH JUNE 28, 1984	MONTH DAY YEAR	2b. HOUR 4:03 M
1. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH OCT DAY 19 YEAR 1957	6. AGE (IN YEARS LAST BIRTHDAY) 26 IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE COUNTRY MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.	13b. COUNTY BALTO.	13c. CITY OR TOWN ESSEX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3008 HOLLY NECK RD. BALTO. 21221				
14. FATHER'S NAME FIRST LOUIS	MIDDLE	LAST OLDEWURTEL	15. MOTHER'S MAIDEN NAME FIRST ELsie	MIDDLE	LAST DOBSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 213-68-3709	17. INFORMANT Husband KENNETH SMITH	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR.					
DO TO, OR AS A CONSEQUENCE OF (b) SPLEENECTOMY			12 HRS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION 6-27-84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED THROMBOTIC THROMBOCYTOPENIA			20a. AUTOPSY? <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-8-84 to 6-28-84 , that (I) (we) last saw the deceased alive on 6-28-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE J. D. Jabs	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 6-28-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. LABBS	22e. ADDRESS 600 N. WOLFE ST. BALT. MD. 21205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JUNE 30, 1984	23c. NAME OF CEMETERY OR CREMATORIAL HOLLY HILL	23d. LOCATION CITY OR TOWN WHITE MARSH	COUNTY BALTO. MD.	STATE MD.			
24. FUNERAL DIRECTOR NAME CONNELLY Funeral Home 300 MACE AVE	ADDRESS	25a. DATE REC'D. BY REGISTRAR JULY 3 1984	25b. REGISTRAR'S SIGNATURE Davidson Pendell					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Please sign and complete this certificate within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called and informed.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 4 1 6 3 0 5

I. DECEASED NAME (TYPE OR PRINT)			FIRST Helen	MIDDLE M	LAST Smith	2a. DATE OF DEATH MONTH 06	DAY 11	YEAR 84	2b. HOUR 10 ¹⁵ AM	
3. SEX Female			4. RACE White	5. DATE OF BIRTH MONTH 07		DAY 28	YEAR 16	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 67	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY Hosp, Balto. Md.		12a. USUAL OCCUPATION (TYPE OF WORK FORMOST OF WORKING LIFE) Ket. Machine Operator, King Syrup			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY A.A.C.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 5805 Larson St. 21061 22 S. GREENE ST	
14. FATHER'S NAME FIRST Ludwig			MIDDLE -----	LAST Style	15. MOTHER'S MAIDEN NAME FIRST Josephine			MIDDLE -----	LAST Dec.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-05-4501		17. INFORMANT Mrs. H. Priscilla Saffran, Same as above			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360			caudate respiratory shutdown					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Massive CVA = braindeath			DUE TO, OR AS A CONSEQUENCE OF (b)							
			DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) <input checked="" type="checkbox"/> (his hospital) attended the deceased from 6/7 , 19 84 , to 6/11 , 19 84 , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6/11 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE P. Siemer		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 6/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Siemer MD		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 14, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Balto, National Cemetery		23d. LOCATION CITY OR TOWN Baltimore, Maryland		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME McGilly Funeral Home, 130 E. Fort Ave. Balto. Md.		ADDRESS 21230		25a. DATE REC'D. BY REGISTRAR JUN 12 1984		25b. REGISTRAR'S SIGNATURE S. Davidson-Henderson				

10.11.88 10.9

Helen M Smith

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Bethune University

NY SCENE 72

10.11.88

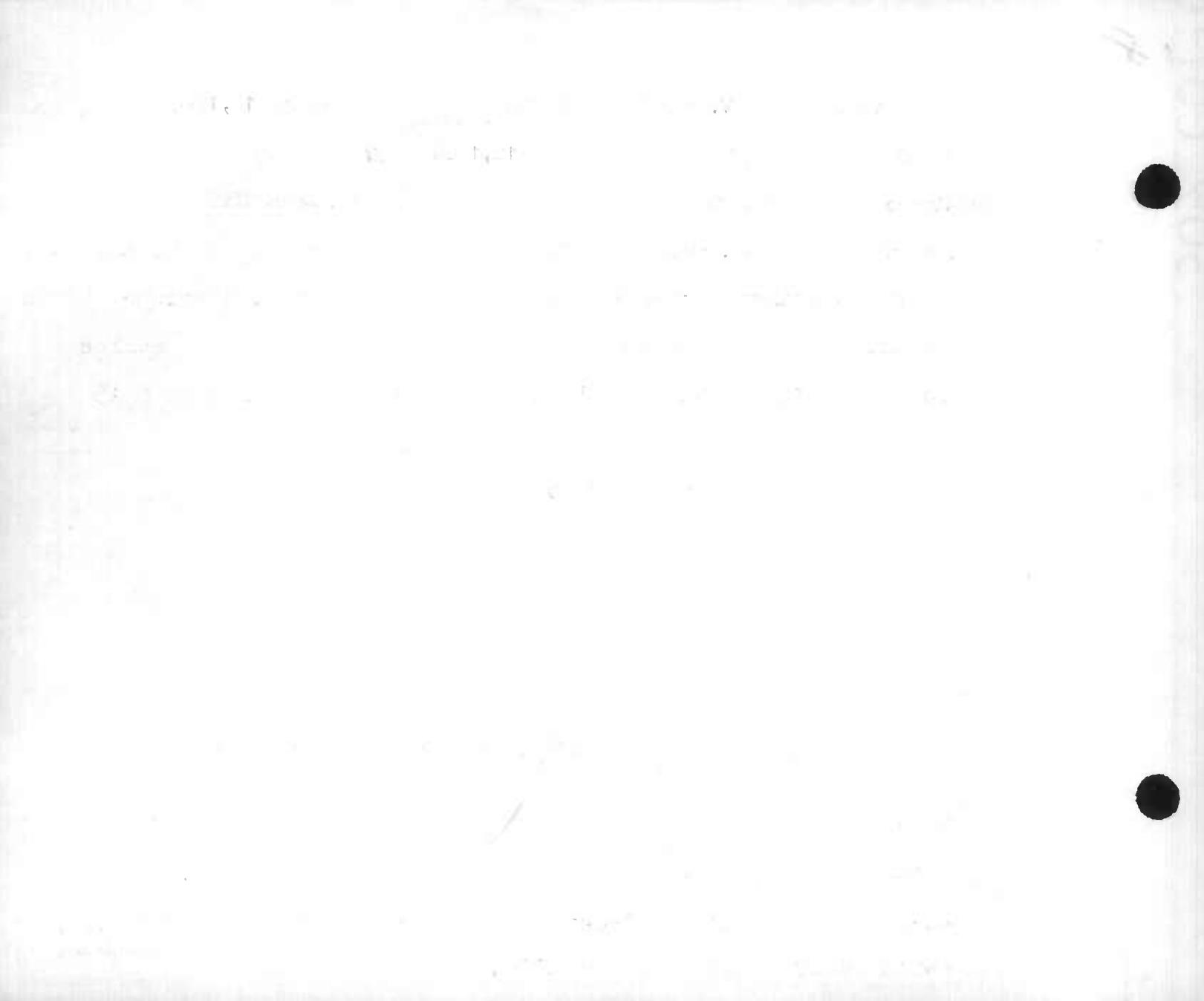
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical certificate must be furnished.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 4 1 6 3 0 5						
1 - FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR JUNE 18, 1984							2b. HOUR 10:00 AM						
I. DECEASED NAME FIRST MARTHA MIDDLE Virginia LAST SMITH			5. DATE OF BIRTH 7/12/24 MONTH DAY YEAR JULY 12, 1924			6. AGE (IN YEARS LAST BIRTHDAY) 59 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.										
3. SEX FEMALE			4. RACE WHITE			7. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector			12b. KIND OF BUSINESS OR INDUSTRY Koppers Co.							
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Catonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 14A Sanford Avenue 21228				
14. FATHER'S NAME FIRST Albert MIDDLE L. LAST Smith			15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE LAST Eckles													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Miss Ann A. Smith			ADDRESS Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD (c) DOUE TO, OR AS A CONSEQUENCE OF DOUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) this physician attended the deceased from 18 June 1984 to 18 June 1984, (II) we last saw the deceased alive on 18 June 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (III) (we) (did) (did not) view the body after death.																
22b. SIGNATURE DEGREE <i>David A. Jung</i>										22c. DATE SIGNED 6/19/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Jung, M.D.			22e. ADDRESS 900 S. Caton Ave. Balto., Md. 21229													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/21/84			23c. NAME OF CEMETERY OR CREMATORIAL Crest Lawn Gardens			23d. LOCATION CITY OR TOWN West Friendship Ho., Md.			23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home ADDRESS Catonsville, Md.										25a. DATE REC'D. BY REGISTRAR JUN 19 1984			25b. REGISTRAR'S SIGNATURE <i>Marion Pendleton</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 0 7	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Violetta E. Smith</i>						06	07	84				23.10PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
<i>Female</i>			<i>White</i>			MONTH	DAY	YEAR	73	YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
<i>Turk</i>			<i>U.S.A.</i>			<i>21711911</i>			<i>Baltimore City</i>			<i>House wife</i>	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Baltimore city</i>			<i>St Agnes Hosp.</i>			<i>House wife</i>			<i>at Home</i>				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE	
<i>Md.</i>			<i>Baltimore</i>			<i>Baltimore</i>						<i>1810 Francis St. 21230</i>	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
<i>William P. Sheldon</i>						1st	MIDDLE	LAST	<i>Estella Leabrease</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>No</i>			<i>215-21-4839</i>			<i>William Sheldon</i>			<i>1164 Nanticoke St.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF			ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE				
<i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) EMPHYSEMA							
						(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
						<i>5/2 83</i>			<i>06/07 1984</i>			<i>06/07</i>	<i>1984</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>06/02 1984</i> to <i>06/07 1984</i> , and that in (my) <i>Yen</i> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			<i>6/8/84</i>	
<i>Kuang-Yen Huang MD</i>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
<i>KUANG-YEN HUANG</i>			<i>517 Scott St Balt MD 21230</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY	
<i>Burial</i>			<i>6/11/84</i>			<i>Glen Haven Cemetery</i>			<i>Glen Burnie</i>			<i>MD</i>	
24 FUNERAL DIRECTOR			ADDRESS			25a. DATE RECEIVED IN REGISTRY			25b. REGISTRAR'S SIGNATURE				
<i>John J. Chonowicz Son Inc.</i>			<i>Collins St. 21230</i>			<i>4/1/84</i>			<i>J. J. Chonowicz</i>				

- 48 7% 48 $\frac{5}{2}$ " 22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

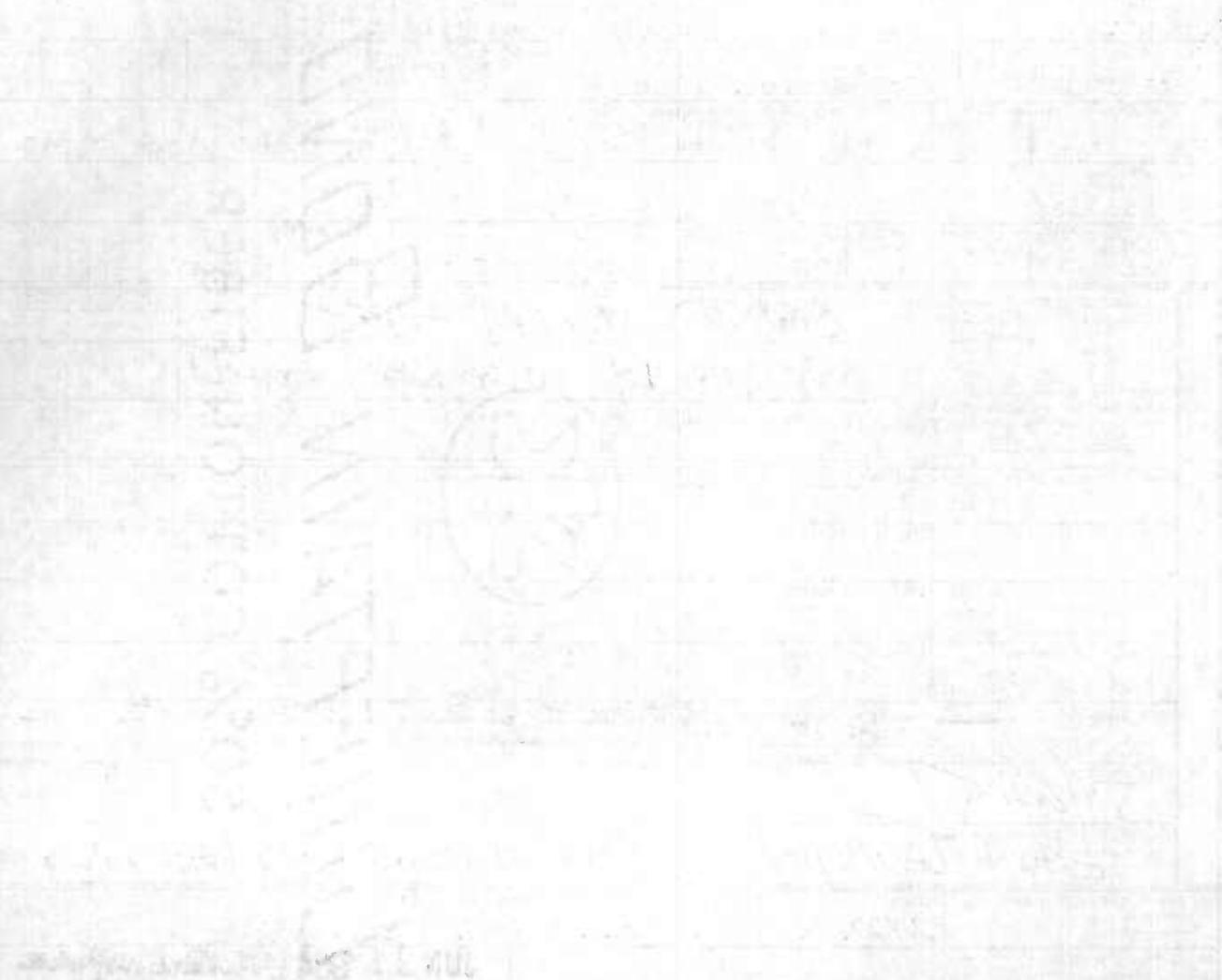
IMPORTANT: If Item 21 is marked or torn, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 4 1 6 3 0 8			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
WILLIAM		R.		SMITH	JUNE 18, 1984					M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		black		9 14 16		67		MONTHS DAYS		HOURS MIN.			
YRS.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Kentucky		U.S.A.				BALTIMORE CITY, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		513 Sanford Place											
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland			Baltimore			513 Sanford Place 21217							
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
William			Smith	Ruth									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		400-24-4410		Gregory Smith		513 Sanford Place							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLY PULMONARY EMBOLI</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 13, 1983</u> , to <u>June 19, 1984</u> , that (I) (we) lost saw the deceased alive on <u>June 13, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Segun Lawoyin</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/22/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SEGUN LAWOYIN</u>		22e. ADDRESS <u>200 W. COLONIAL SPRINGS LANE, BALTIMORE</u>											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/22/84		23c. NAME OF CEMETERY OR CREMATORIAL Md. Veteran Cem.		23d. LOCATION CITY OR TOWN <u>Crownsville</u>		COUNTY		STATE <u>Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H Inc.</u>		ADDRESS <u>1101 E North Ave.</u>		25a. DATE REC'D. BY MEDICAL EXAMINER <u>JUN 21 1984</u>		25b. REGISTRATION NUMBER <u>J. J. Johnson-Pendell</u>		SIGNATURE <u>J. J. Johnson-Pendell</u>					
BP _____													
DHMH 16 30M 2/80 (VRA 15, 4)													

A

DR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. FOR STATE REGISTRAR				8 4 1 6 3 0 9											
1. DECEASED NAME (TYPE OR PRINT)				FIRST MARVIN	MIDDLE L	LAST SMOYER	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 9:23 AM				
3. SEX Male				4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1945			6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA				7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		10. CITY OR TOWN OF DEATH BALTIMORE			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Schramms, Inc.								
13a. STATE PA				13b. COUNTY MD			13c. CITY OR TOWN W. Chester			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 307 S. Concord St. 19380			
14. FATHER'S NAME FIRST Claude				MIDDLE Smoyer	LAST	15. MOTHER'S MAIDEN NAME FIRST Julia			MIDDLE Summers	LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 178 36 3878	17. INFORMANT Wetzler Funeral Home, Bellefonte, PA
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 2000				DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC DIFFUSE HISTIOCYTIC LYMPHOMA			DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6/18 , 19 84 , to 6/10 , 19 84 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 6/10 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did (did not) view the body after death.															
22b. SIGNATURE Richard M. Hodges,			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/10/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. HODGES, M.D.			22e. ADDRESS 600 N. Wolfe St			BALTIMORE CITY HOSPITAL, BALTIMORE MD 21224									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial			23b. DATE 6/14/84			23c. NAME OF CEMETERY OR CREMATORIAL CENTER Center Co. Mem. Pk.			23d. LOCATION CITY OR TOWN Center County, PA						
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.			ADDRESS 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR JUN 11 1984			25b. REGISTRAR'S SIGNATURE Juliannson-Rendell						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please advise.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the Burial Form (Burial Permit). Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT! If item 21 is marked as item 18, забыть any injury or other traumatic event! The medical examiner will be asked to investigate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 1 0				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>Carl John Snack</i>								<i>6-15-84</i>						<i>10:15 A</i>		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
<i>Male</i>		<i>White</i>		<i>2-16-14</i>			<i>70</i>			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.						
<i>Balto. Md.</i>		<i>U.S.A.</i>		<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>			<i>Baltimore City</i>			<i>MD.</i>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
<i>Baltimore</i>		<i>Baltimore City Hospital</i>										<i>Retired</i>			<i>General Motors</i>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
<i>Md.</i>		<i>Balto.</i>		<i>Balto.</i>						<i>7102 E. Biddle St. -21237</i>						
14. FATHER'S NAME		FIRST	MIDDLE	LAST			15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	ADDRESS				
<i>Charles Snack</i>							<i>Anna Diesel</i>					<i>21237</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
<i>No</i>				<i>216-01-5187</i>			<i>Mrs. Myrtle M. Snack - 7102 E. Biddle St.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i>																
4100 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first (b) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from <i>54NE</i> , 19 <i>1976</i> , to <i>JUNE</i> , 19 <i>84</i> , that (I) <input type="checkbox"/> lost saw the deceased alive on <i>3-10</i> , 19 <i>84</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death.																
22b. SIGNATURE <i>F. S. Palmisano</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED <i>6-16-84</i>						
22e. ADDRESS <i>5122 Hartford Rd. Balto. Md. 21214</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-18-84</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardens of Faith Cem.</i>			23d. LOCATION CITY OR TOWN <i>Balto. Md.</i> COUNTY <i>Md.</i> STATE									
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc</i>		ADDRESS <i>6415 Belair Rd. -21206</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 19 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Sylvia Davidson-Randall</i>									

11-21-01

11-21-01

Domestic (ex)

05

11-21-01

other

other

(ii) monetary

x

11-21-01

in other

11-21-01 Domestic

11-21-01

Domestic (ii) monetary

monetary

TESIS - 11-21-01 3 2015 x

other

other

in

Domestic non

Domestic

TESIS
11-21-01 3 2015 - Domest. & others non 11-21-01

Domestic - Domestic non

(i) other

(ii) Monetary (ex)

11-21-01

Domestic

TESIS - 11-21-01 3 2015 - Domest. & others non 11-21-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Item #6 Film #G592

6/12/84 JP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 4 1 6 3 1 1

1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR										2b. HOUR							
		5/5/84										8:40 A.M.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST (Leeana) MIDDLE		Snell LAST		3. SEX		4. RACE		5. DATE OF BIRTH MONTH 10 DAY 28 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Leana		(Leeana)		Snell		Female		Black											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.													
MD		USA																	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
MD		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		1102 Druid Hill Ave. 21201									
14. FATHER'S NAME Milton		MIDDLE		LAST Turner		15. MOTHER'S MAIDEN NAME Mary		MIDDLE Jackson		LAST Turner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		17. INFORMANT Calvert Thomas		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Unkn		213-32-7483		5280															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure		18b. DUE TO, OR AS A CONSEQUENCE OF (b) CHF. COPD.		18c. DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		P.M.		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from 5/15/84, 19_____, to 5/15/84, 19_____, that (I) (we) last saw the deceased alive on 5/15/84, 19_____, and that (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>S. Sissay Jr.</i>		22c. DEGREE MS		22d. ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 5/15/84									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) S. Sissay Jr.		22g. ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/9/84		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery		23d. LOCATION Laurel		23e. CITY OR TOWN		23f. COUNTY		23g. STATE MD							
24. FUNERAL DIRECTOR NAME Wm C March Funeral Home		ADDRESS 1101 Enchanted		25a. DATE REC'D. BY REGISTRAR MAY 8 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Kendall													



100 J YAH

(A)

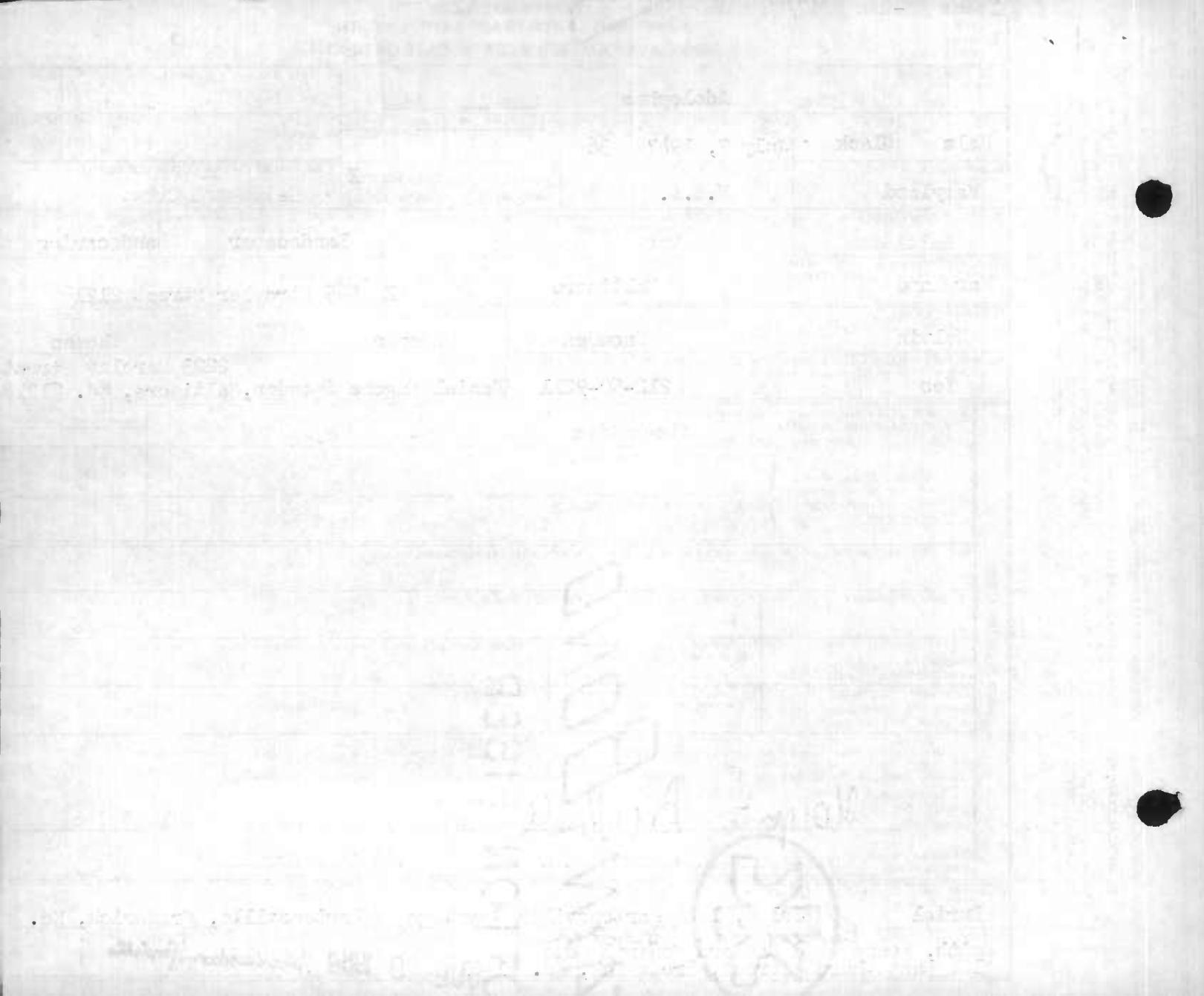
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 4 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	XX	MONTH	DAY	YEAR	2b. HOUR
Brice Adolphus Snowden							6-30	1984				
3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
Male	Black	July 7, 1947	36 yrs	MONTHS	DAYS	HOURS	6-30	1984				10:02 p.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY, MD.				
Maryland	U.S.A.				Baltimore City,							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore	University Hospital			Landscaper			Landscaping					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			ADDRESS			
Maryland		Baltimore	NO			565 Stroyler Street 21218			2223 Barclay Street			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
	Melvin		Snowden	Madonna					Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			2223 Barclay Street					
Yes	212-50-9211			Daniel Eugene Snowden, Baltimore, Md. 21218								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3030 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?			
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY	23f. STATE			
Burial	Jul 6, 1984	Bartonsville Cemetery			Bartonsville, Frederick, Md.							
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	Jul 9, 1984			Julia Davidson Rendall								

BP 778

DHMH - 17
(VR A15 ME (5))
20M 4/82



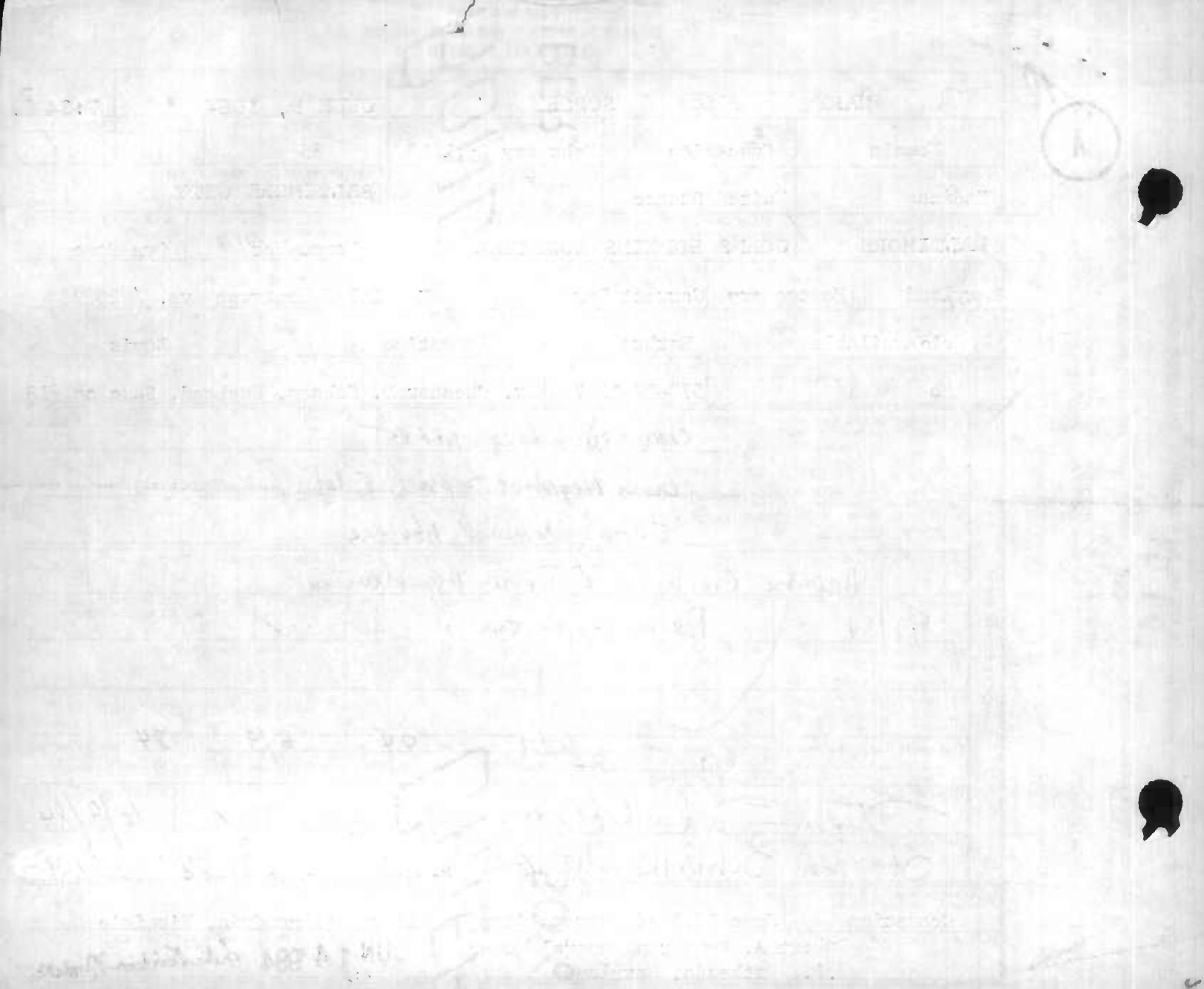
TO HOSPITAL OR ATTENDING PHYSICIAN: This long form death certificate is executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, pages 1 and 2 should be detached for use as the burial permit. Then please return carbon portion, Pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 above, any injury or other terminal event (the medical term) which caused the death should be described in Part 2.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 1 6 3 1 3					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE Alice	LAST SOBSEY		2a. DATE OF DEATH JUNE 9, 1984			MONTH DAY YEAR	2b. HOUR 7:34 P				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH February		DAY 26	YEAR 1919	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Garrett Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10705 Montrose Ave. / 20896							
14. FATHER'S NAME FIRST John		MIDDLE Barbre		LAST		15. MOTHER'S MAIDEN NAME FIRST Clementine		MIDDLE		LAST Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 573-09-1387		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5723 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) Bacitrac Negative Sepsis (E. coli, Enterococcus)		DUE TO, OR AS A CONSEQUENCE OF (c) Intra Abdominal Abscess													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Hepatic Cirrhosis & Portal Hypertension															
19a. DATE OF OPERATION 5/9/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PORTAL HYPERTENSION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) PORTAL HYPERTENSION											
21d. INJURY OCCURRED AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 600 N. Wolfe		CITY OR TOWN Baltimore		COUNTY Md 21205	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 84 , to 6/9 , 19 84 , that (I) (we) last saw the deceased alive on 6/4 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 6/9/84			
22b. SIGNATURE Stephen Schurknight		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Schurknight		22e. ADDRESS 600 N. Wolfe Baltimore Md 21205													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 10, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria, Virginia		COUNTY	STATE						
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 14 1984		25b. REGISTRAR'S SIGNATURE Julie Davidson-Pender							



P.C. 3
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	4	1	6	3	1	4
										REG. NO. 6 19 84						
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
		STEPHEN R					SOLOMON	6 19 84						750 AM		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE			MONTH 10 DAY 30 YEAR 1948			35			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTO. <i>Baltimore City MD</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY								
BALTO CITY		UNIV OF MD. HOSPITAL														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		OWINGS MILLS Rosewood CENTER 21117						
MD		BALTO.		OWINGS HILLS		Elaine				Hinton						
14. FATHER'S NAME FIRST		MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			17 INFORMANT ADDRESS								
JOHN		E			Elaine			Mrs. Elaine Solomon, Hampstead, Md.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
no <input type="checkbox"/>		812 78 4892														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										<i>CARDIOPULMONARY ARREST</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF <i>OVERWHELMING INFECTION</i>						
(b)																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22e. I certify that (I) (this hospital) attended the deceased from <u>6/18/84</u> to <u>6/19/84</u> , that (I) (we) lost saw the deceased alive on <u>6/18/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>6/19/84</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
SALVATERRA		UNIV OF MD. HOSPITAL														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		6-21-84		Lorraine Pk. Cem.			Woodlawn		Balto		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Eline Funeral Home, Hampstead, Md. 21074					JUN 27 1984			<i>Julia Dawson-Randall</i>								

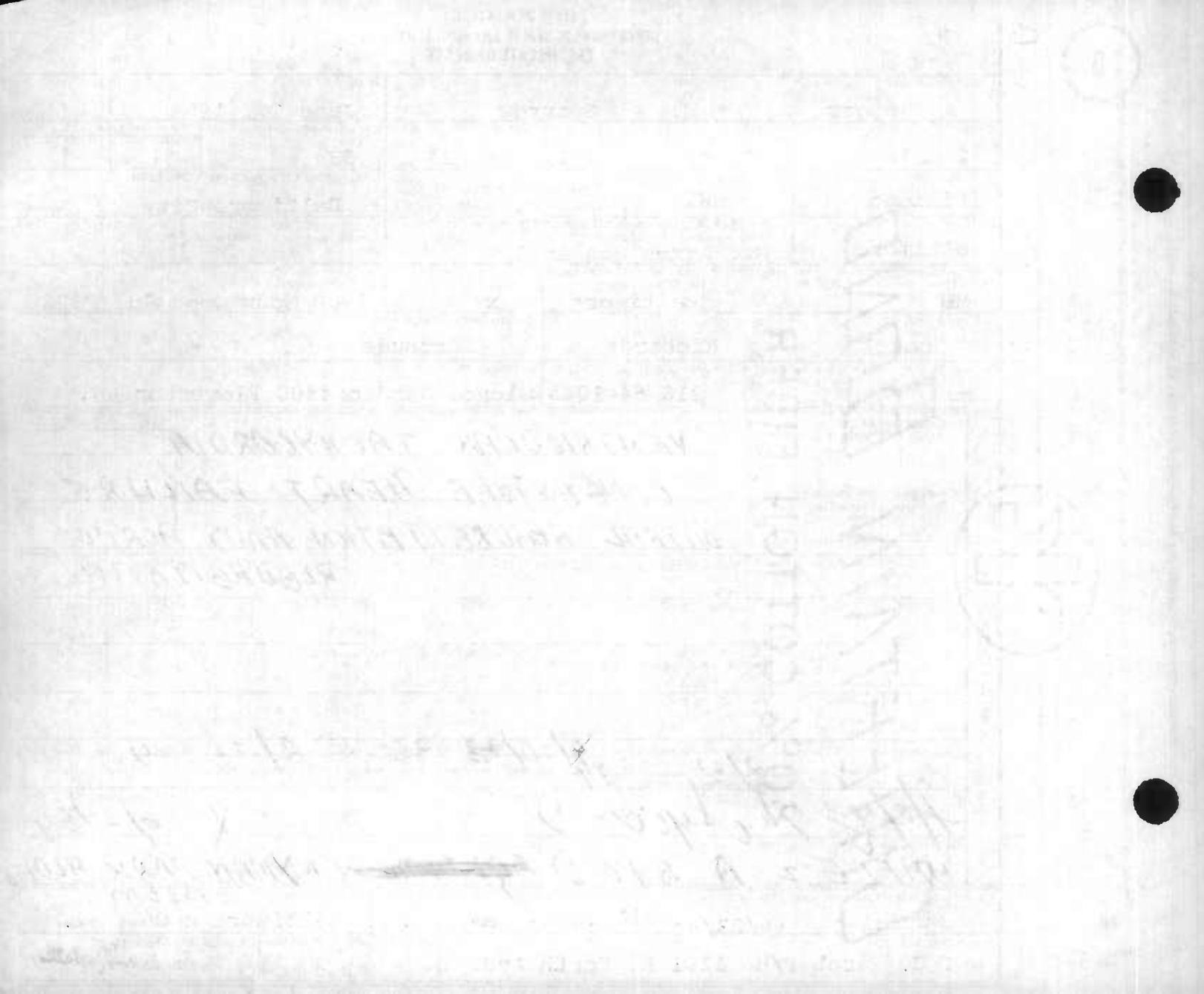
24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8 4 1 6 3 1 5											
1 - FOR STATE REGISTRAR			I. DECEASED NAME FIRST			MIDDLE			LAST		
Hagar			M.			Sparrow					
3 SEX Female			4 RACE Black			5. DATE OF BIRTH MONTH 11 DAY 5 YEAR 25			6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trinidad			7b CITIZEN OF WHAT COUNTRY? BWI			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3900 Mountwood Rd. 21229		
14 FATHER'S NAME FIRST Samuel MIDDLE Richards LAST			15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-64-1045			17. INFORMANT Glenda Jordan			ADDRESS 4400 Flowerton Rd.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR TACHYCARDIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE											
(c) MITRAL REGURGITATION AND AORTIC REGURGITATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/22/84, 1984, to 2/22/84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE HAFEEZ A. SPYDER			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/21/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEEZ A. SPYDER			22e. ADDRESS			23d. LOCATION CITY OR TOWN Baltimore COUNTY SYSTEM Co. STATE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/23/84			23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem. Pk.					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 22 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

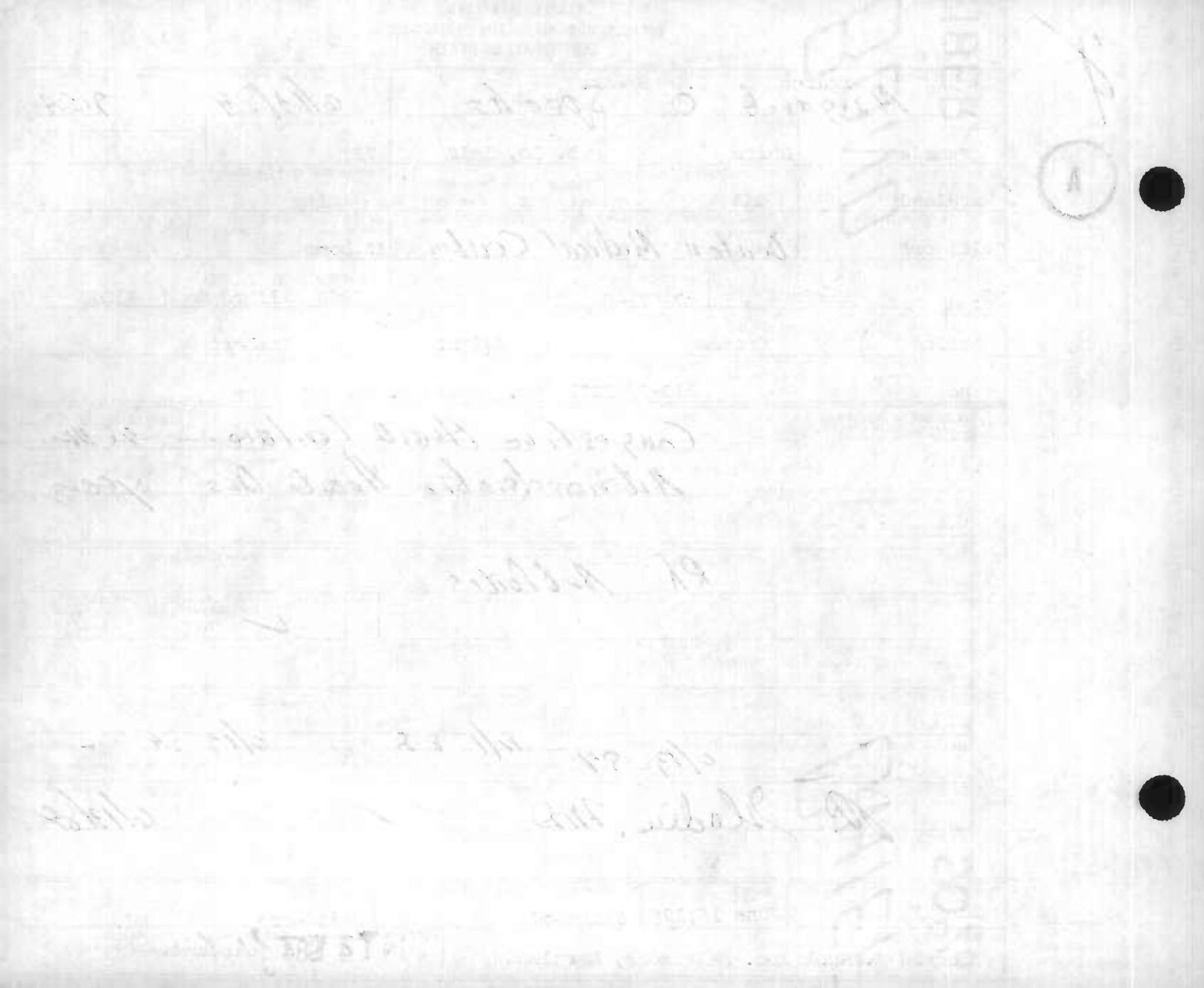
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	4	1	6	5	!	0	
1 - FOR STATE REGISTRAR										REG. NO.							
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Margaret			E.	Sparrow				June 11, 1984									
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		White		Month Day Year			Aug. 29, 1918			65	YRS.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U.S.A.								Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		431 E. 31st Street			Bookkeeper			Md Natl Bk									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland				Baltimore						431 E 31st st. 21218			==2128=				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST									
Jaybus		Bryant		Lydia				Risener									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
		254-10-5549			Kassandra Hollis			431 E. 31st St. 21218									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										CARDIOPULMONARY ARREST							
(b) DUE TO, OR AS A CONSEQUENCE OF CORONARY ARTERY DISEASE																	
(c) DUE TO, OR AS A CONSEQUENCE OF HYPERTENSION																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
DIABETES MELLITUS																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/26, 1983, to 5/17, 1984, that (I) (we) last saw the deceased alive on 5/17, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Miguel Karacuschansky MD										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6-12-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Miguel Karacuschansky MD										22e. ADDRESS 300 E. 33rd Street Baltimore, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION										
Burial		6/15/84		Holy Redeemer			Baltimore, Md										
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Leonard J. Ruck Inc.		Baltimore, Maryland						JUN 13 1984									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 1 7
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	Margaret	FIRST	MIDDLE	LAST	Speaks		2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	72	YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	City	MD.					
10. CITY OR TOWN OF DEATH	Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Deacon Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	At home	12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE	Md.	13b. COUNTY	Harford	13c. CITY OR TOWN	Abington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2908 Salford Road 21209					
14. FATHER'S NAME	Charles	FIRST	MIDDLE	LAST	Lulent	FIRST	MIDDLE	LAST				
15. MOTHER'S MAIDEN NAME	Cramer				Lambert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no	16b. SOCIAL SECURITY NO.	213-20-3227	17. INFORMANT	Mr. Ronald L. Cramer Same	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 46 min.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RH Atherosclerosis												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 14 82 to 213 19 84										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE							
22a. I certify that (this hospital) attended the deceased from saw the deceased alive on 6/19 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) did not view the body after death.)												
22b. SIGNATURE J.R.	22c. DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 6/13/84						
22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE June 16, 1984	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood	23d. LOCATION CITY OR TOWN Baltimore	COUNTY	STATE	Md.						
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland	ADDRESS	25. SIGNED AND REGISTERED BY REGISTRAR AND REGISTRAR'S SIGNATURE JUN 14 1984 Julie Davidson-Kendall										

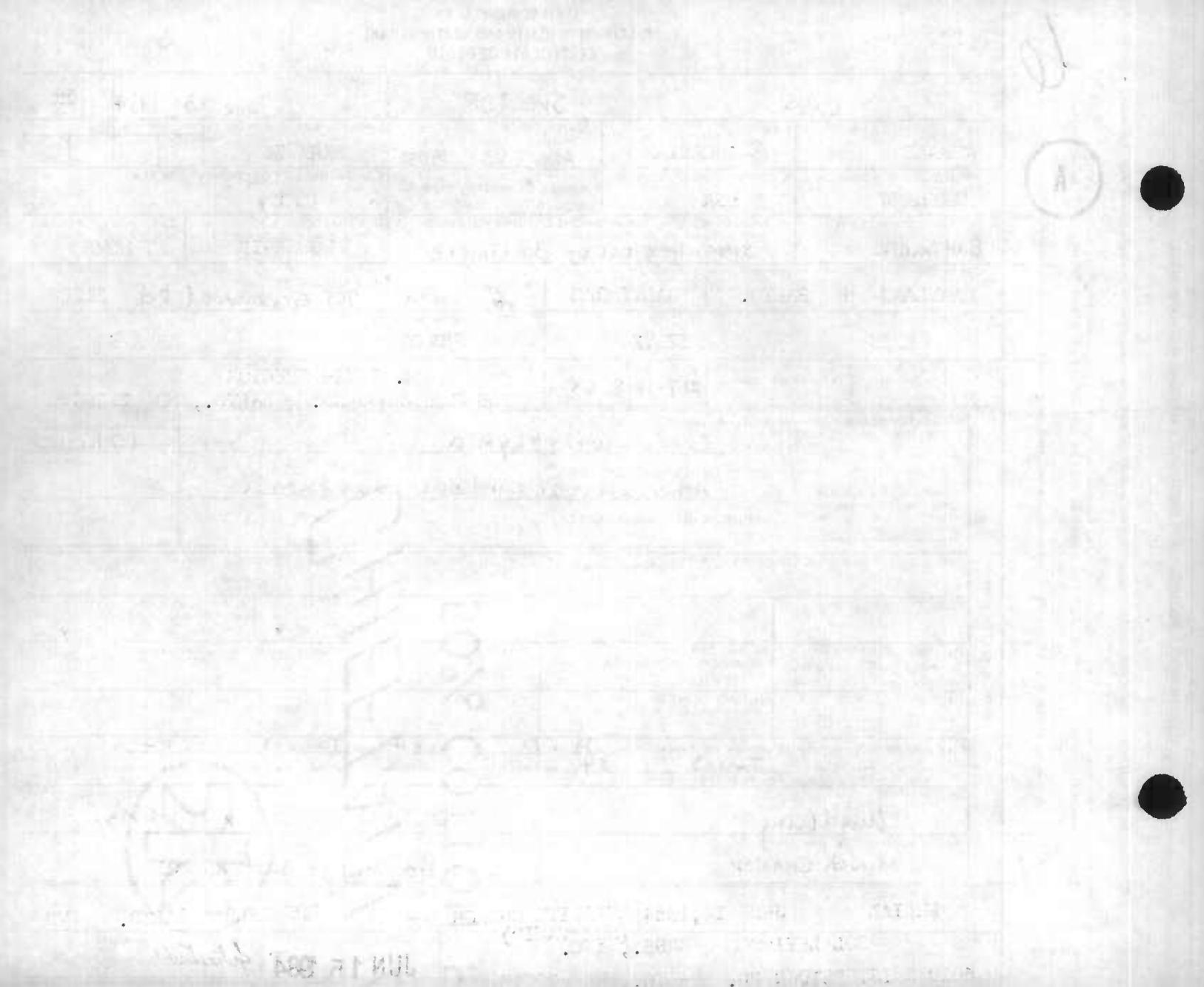


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 1 8								
												REG. NO.								
1. FOR STATE REGISTRAR			1. DECEASED NAME			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR							
			EDNA			SPECTOR			June 13 1984			1984	11 44 A.M.							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE			IN YEARS LAST BIRTHDAY		IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE			CAUCASIAN			MONTH DAY YEAR			XX 78			YRS.		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE			7b. STATE OR FOREIGN COUNTRY			8. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MARYLAND			USA			BALTIMORE						City								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore			SINA Hospital of Baltimore			HOUSEWIFE			AT HOME											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
MARYLAND			BALTO.			BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			705 Greenwood Rd 21208								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
MORRIS			JENNY			(YES, NO OR UNKNOWN)			217-16-8863 A			MR. IRVIN SPECTOR			705 GREENWOOD RD. BALTO., MD 21208					
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerotic cardiovascular disease</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 hours					
19. MEDICAL CERTIFICATION			20. DATE OF OPERATION			21. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE								
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 12</u> , 19 <u>84</u> , to <u>June 13</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>June 13</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE MING CHANG			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 6/13/84								
22e. PHYSICIAN'S NAME (TYPE OR PRINT)						22f. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL (NER TAMID)			23d. LOCATION CITY TOWNSHIP COUNTY STATE		
BURIAL			JUNE 14, 1984			LUBAWITZ NUSACH ART INC.			ROSEDALE BALTO., MD			JUN 15 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall					
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
SOL LEVINSON & BROS.																				
6010 REISTERSTOWN RD.			BALTO., MD 21215																	



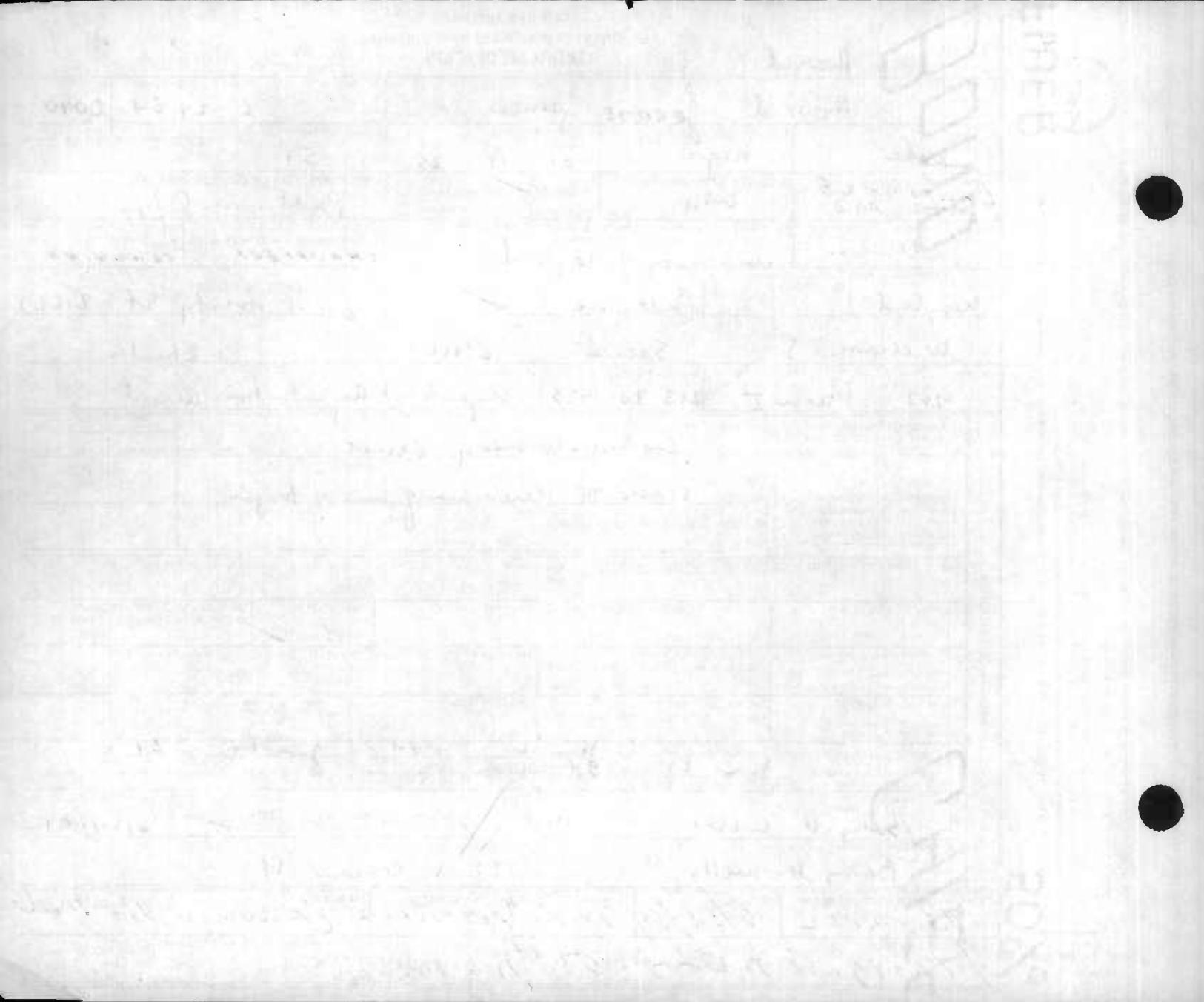
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

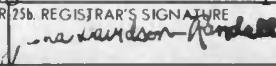
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. FOR STATE REGISTRAR			Howard									8 4 1 6 3 1 9					
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Howard			J E R O M E			Spence			6 24 84						00 10 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male			Negro			MONTH DAY YEAR			59			MONTHS	YEARS	MONTHS	HOURS	MIN.	
7. BIRTHPLACE			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore MD			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Baltimore City, MD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore			University of Maryland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			205 N. Trinity St. 21223					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			15. MOTHER'S MAIDEN NAME								
Maryland			Baltimore			Baltimore			Elise								
14. FATHER'S NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES, NO OR UNKNOWN 903			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
William S			WW II			213-20-1433			Immediate Registration Record								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) STAGE II carcinoma of base of tongue DUE TO, OR AS A CONSEQUENCE OF (c)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 12, 1984, to June 24, 1984, that (I) (we) last saw the deceased alive on June 23, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Barry H. Wells			22c. DEGREE MD									ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 6/24/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry H. Wells			22e. ADDRESS 22 S. Greene St.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6/25/84			23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans			23d. LOCATION Crownsville, MD								
24. FUNERAL DIRECTOR NAME Mark Farrell Shagin			ADDRESS 238 N. 9th St.			25a. DATE REC'D. BY REGISTRAR JUN 27 1984			25b. REGISTRAR'S SIGNATURE John W. Phillips								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 2 0				
												REG. NO.				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			SOPHIA KATHERINE SPURRIER						6 25 84						4:50 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR			88			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE, City MD.				
Maryland			U.S.A.			Jan 30, 1896										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE, CITY			UNION MEMORIAL HOSPITAL			Secretary			Insurance							
13a. STATE Maryland			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6131 Parkway Drive 21212							
14. FATHER'S NAME John A. Streb						15. MOTHER'S MAIDEN NAME Isabel										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 212-07-8904			17. INFORMANT Mr. S.R.Minsker 421 Range Road 21204			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic cancer (obstructive Tardice)</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 days				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Pancreatic Tumor</u>																
19a. DATE OF OPERATION 6/11/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED obstructive Tardice			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> , 19 <u>84</u> , to <u>6/25</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 6/25/84				
22b. SIGNATURE 			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Earl Stokes Jr.			22e. ADDRESS 201 E. UNIVERSITY PKWY./UNION HOSPITAL						MEMORIAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-28-84			23c. NAME OF CEMETERY OR CREMATORIAL Lewisburg Cemetery			23d. LOCATION CITY OR TOWN Lewisberg			COUNTY	STATE			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Road 21212			25a. DATE REC'D. BY REGISTRAR JUN 29 1984			25b. REGISTRAR'S SIGNATURE 										

100

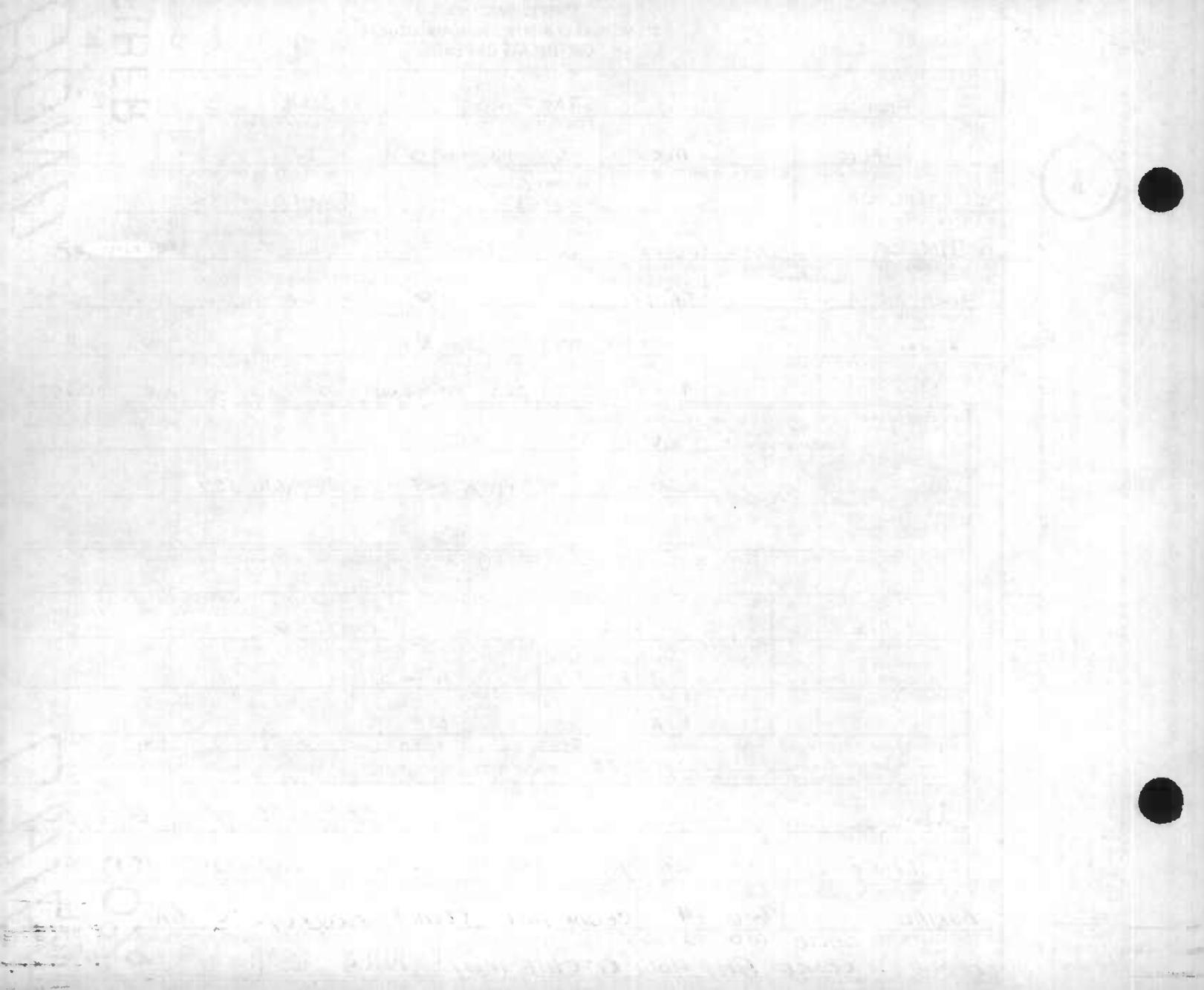
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the records of your death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	JUNE 3 1984									2 44 AM		
FRANK C. STAFFORD																	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
MALE			CAUC.			MONTH 7 DAY 16 YEAR 1913			70 YRS.			MONTHS			DAYS HOURS MIN.		
7b. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
N. CAROLINA			US									BALTIMORE CITY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE			SOUTH BALTIMORE GEN. HOSP.			WELDER			SELF-EMP.								
13a. STATE MARYLAND			13b. COUNTY A.A.			13c. CITY OR TOWN BROOKLYN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 109 CAMROSE AVE 21225					
14. FATHER'S NAME JOHN			15. MOTHER'S MAIDEN NAME HANNA														
FIRST MIDDLE LAST																	
16b. SOCIAL SECURITY NO. NO			17. INFORMANT AVA STAFFORD			ADDRESS 109 CAMROSE AVE 21225											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7860 IMMEDIATE CAUSE (a) RESPIRATORY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												(b) CHRONIC RESPIRATORY INSUFFICIENCY					
{ DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
NONE																	
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) NA											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA			21f. LOCATION STREET NA			CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 5/13 1984, to 6/3 1984, that (II) (we) lost saw the deceased alive on 6/3 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Florante Richard Mancad			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/3/84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLORANTE RICHARD MANCADA			22e. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-6-84			23c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN MEM.			23d. LOCATION CITY OR TOWN GLEN BURNIE A.A.			COUNTY MO.					
24. FUNERAL DIRECTOR NAME GEORGE J. CONCE FM.			ADDRESS 4001 RITCHIE HWY.			25a. DATE REC'D. BY REGISTRAR JUN 4 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall								
BALTO. MO. 21225																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 2 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be mailed within 72 hours after death to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes", Item 18 shows any injury or other traumatic event that may have occurred during life.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 16022					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Hilda M. Stanton									6-17-84					6:35 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Black		3 19 1911			73 YRS			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Balto. City								
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Defense Work			12b. KIND OF BUSINESS OR INDUSTRY Unknown								
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4000 Groveland Ave. Baltimore, Md. 21215					
14. FATHER'S NAME FIRST Jacob		MIDDLE		15. MOTHER'S MAIDEN NAME LAST Eliza Chapman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-2452		17. INFORMANT James A. Stanton			18. ADDRESS 4000 Groveland Avenue Baltimore, Maryland 21215								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable pulmonary embolism 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hours					
DOUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure										years					
DOUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease										years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Cerebrovascular disease (accident)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 72, to 6-17 19 84, that (I) (we) last saw the deceased alive on 5-30 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>Elijah Saunders</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6-19-84								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ELIJAH SAUNDERS, M.D.		22f. ADDRESS 2 HAMILL RD. 21216													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/22/1984		23c. NAME OF CEMETERY OR CREMATORIUM Maryland National Mem.			23d. LOCATION CITY OR TOWN Laurel,		COUNTY	STATE Maryland					
24. FUNERAL DIRECTOR NAME Nutter & Sons Funeral Home Inc.		24b. ADDRESS 2501 Gwynns Falls Parkway Baltimore, Maryland 21216		25a. DATE REC'D. BY REGISTRAR JUN 19 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>								

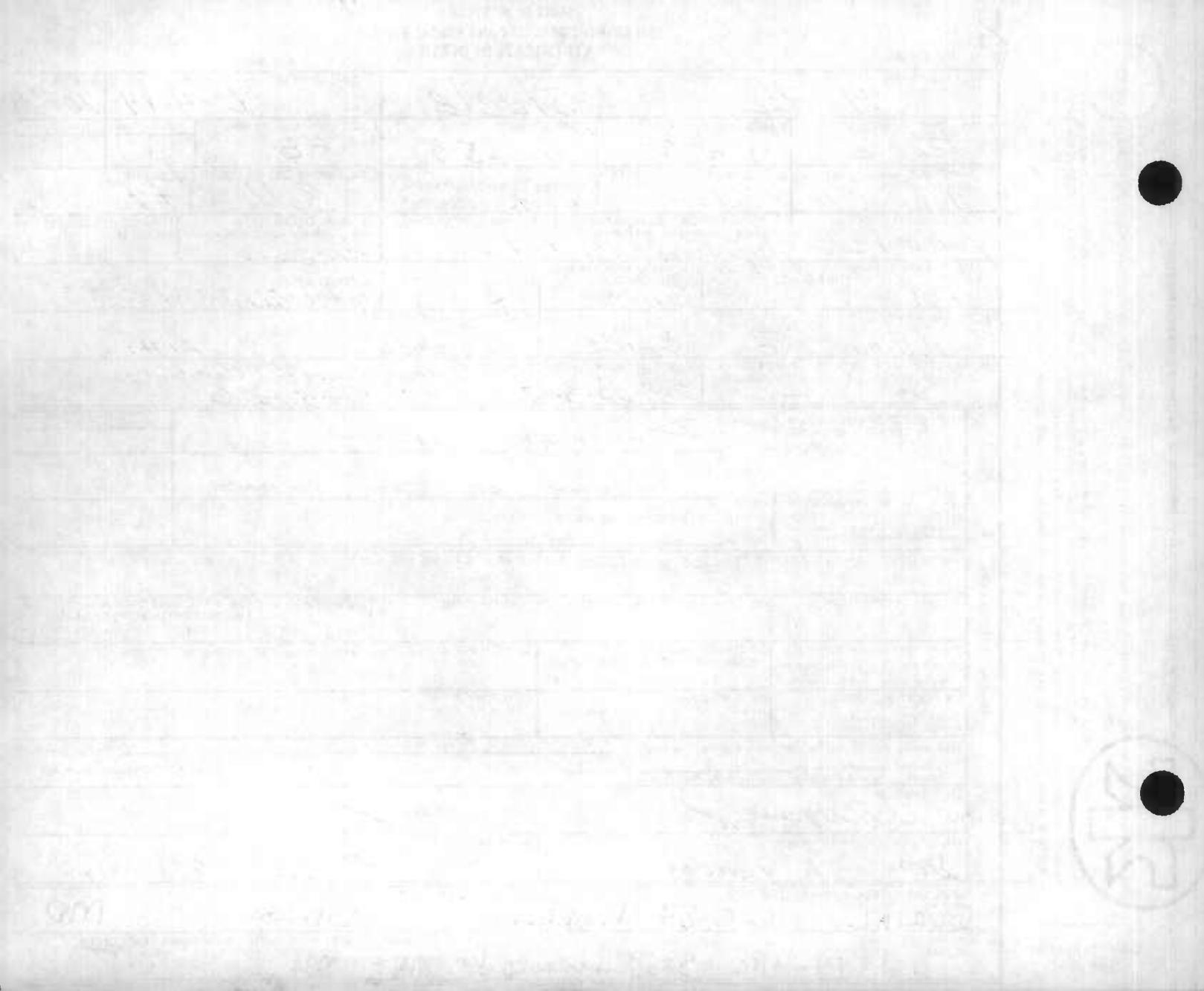
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 4	6 3 2 3			
					REG. NO.				
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)		LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		<i>Myrtle</i>		<i>Steele</i>	<i>6-4-84</i>	<i>6-4-84</i>	<i>10 PM</i>		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
<i>Female</i>		<i>WHITE</i>		<i>9 25 95</i>	<i>88</i>	<i>MONTHS</i>	<i>DAYS</i>	<i>HOURS</i>	<i>MIN.</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Md.</i>		<i>USA</i>			<i>Baltimore City</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY
<i>Baltimore</i>		<i>Harford Gardens Conv. Center</i>		<i>Homemaker</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
<i>Md</i>				<i>Balto</i>				<i>1000 Harford Rd.</i>	
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST
<i>William</i>				<i>Evans</i>	<i>Amanda</i>				<i>Littles</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>No</i>		<i>213-22-3647</i>		<i>Harford Gardens Conv. Center</i>		<i>4700 Harford Rd.</i>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Toniina & Concen</i> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Concen</i> OR TOO KIDNEY. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>S. V. Rock Jr.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6-6-84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<i>Donald S. V. Rock Jr.</i>		<i>4706 Harford Rd., Baltimore MD 21206</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-6-84		23c. NAME OF CEMETERY OR CREMATORIAL MORELAND		23d. LOCATION CITY OR TOWN BALTO.		COUNTY	MD
24. FUNERAL DIRECTOR NAME <i>L. J. Rock Inc</i>		ADDRESS <i>5305 Harford Rd.</i>		25a. DATE REC'D. BY REGISTRAR JUN 5 1984		25b. REGISTRAR'S SIGNATURE <i>L. J. Rock Inc</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 4 1 6 3 2 4
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST HARVEY	MIDDLE C.	LAST STERN	2a. DATE OF DEATH MONTH DAY YEAR 6 10 84
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR 3 4 25		2b. HOUR 3:05a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven Veteran Administration Hosp.			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
13a. STATE Maryland		13b. COUNTY Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2533 Sycramore Ave. 21219
14. FATHER'S NAME FIRST Charles		MIDDLE Stern	15. MOTHER'S MAIDEN NAME FIRST Florence		LAST Dawson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 218-18-4783	17. INFORMANT Florence D. Salmon 5715 Rubin Avenue		ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) intraventricular conduction defect. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a PERIPHERAL VASCULAR DISEASE					
19a. DATE OF OPERATION 5-30-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Thrombosis left femoral artery		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 6 10 1984	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 16 , 19 84 , to JUNE 10 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 10 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE Francis J. Collini		DEGREE MD.	22c. DATE SIGNED 6-11-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. Collini MD		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/14/84	23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest VA	23d. LOCATION CITY OR TOWN Owings Mills, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue	25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE JUN 12 1984		
DHMH - 16 50M 4/B3 (VRA 15, 4)					



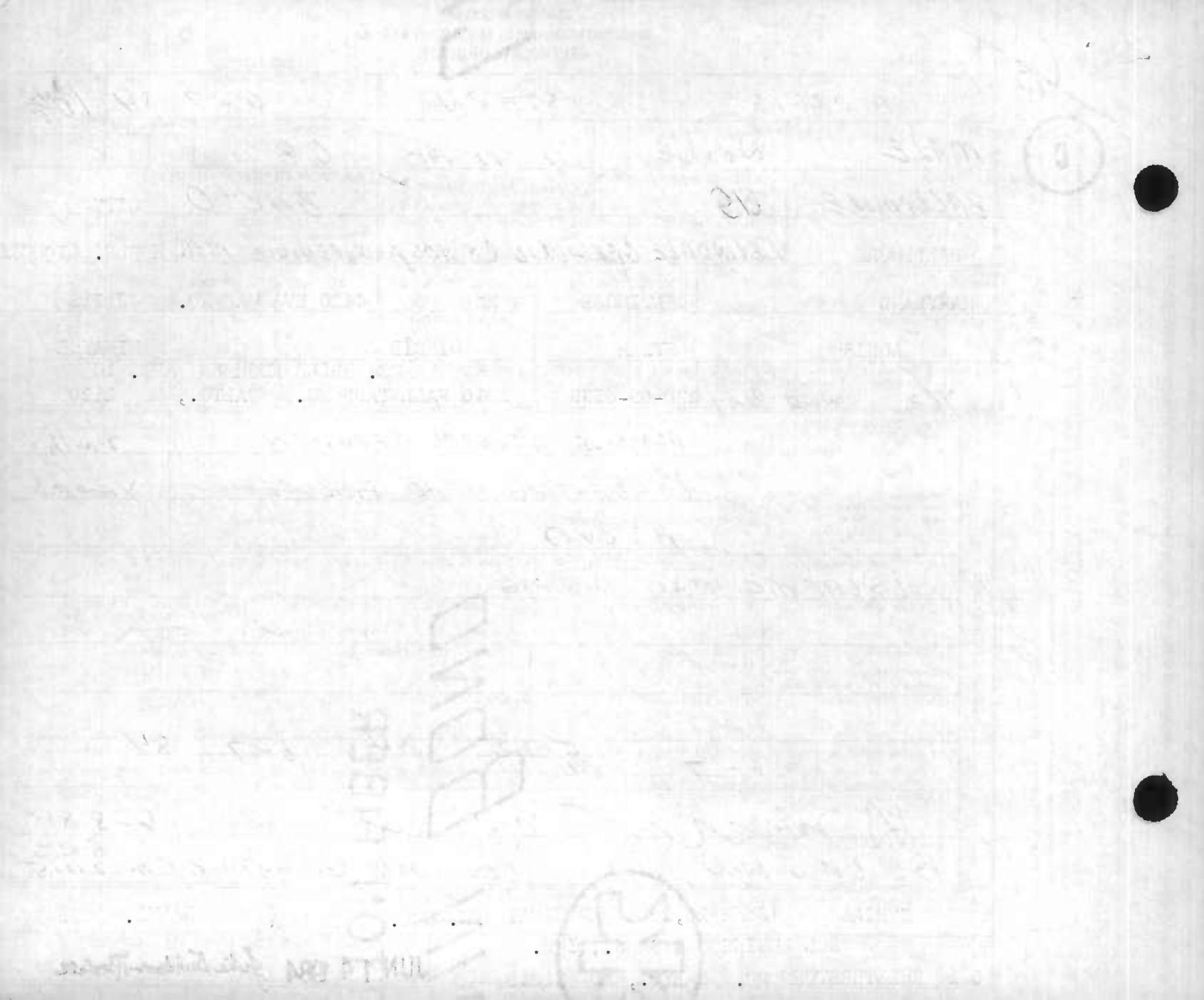
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, please remove carbon paper, page 1 and 2 should be filed with your permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18 shows an injury or other traumatic event, this medical certification must be completed at item 21.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										6 4 1 6 3 2 5			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
MORRIS					STERN	6-7-84		6	7	1984	10:40 AM		
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
MALE			White		11 11 1915		68			IF UNDER 21 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			BALTO CITY MD.			
BALTIMORE			BGS				BALTO						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE			LEVINDALE GERIATRIC CTR HOSP		WAREHOUSE MAN			WHSL. LIQUORS					
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4420 EVA MAE RD. #21215		
14. FATHER'S NAME FIRST LOUIS			MIDDLE STERN		15. MOTHER'S MAIDEN NAME FIRST MINNIE			MIDDLE WINAKUR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWII Army 220-09-6539		17. INFORMANT MRS. BELLE KUSHNER APT. 1C 3010 FALLSTAFF RD. BALTO., MD 21209						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			MASSIVE PLEURAL EFFUSION										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE								YEARS		
			DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			MASSIVE PLEURAL EFFUSION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-22-84 to 6-7-84, that (I) (we) last saw the deceased alive on 6-7-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE H. Whalen, MD			22c. DEGREE MD		22d. ATTENDING PHYSICIAN MD			22e. MEDICAL DIRECTOR MD			22f. STAFF PHYSICIAN MD		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Whalen, MD			22e. ADDRESS LEVINDALE GERIATRIC CTR 21215								22f. DATE SIGNED 6-8-84		
23a. FUNERAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 10, 1984		23c. NAME OF CEMETERY OR CREMATORIAL HAR SINAI BEN. SOC.			23d. LOCATION CITY OR TOWN ROSEDALE			STATE BALTO. MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR JUN 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	4	1	6	3	2	0		
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
SYLVIA									STERN			6		7	84	5 25	P M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7xx		70			IF UNDER 1 YEAR			
FEMALE			WHITE			MONTH 08 DAY 01 YEAR 1913			MONTHS			YRS.					IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD.								
Latvia			US.																	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore			Levinsohn Geriatric C and Hosp			Home maker			APT. 504											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
MD			XXXXXX			Baltimore						5715 Park Heights Ave 21215								
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS								
FIRST ZALMAN						WEINRAUB			FIRST ROSE			MIDDLE RAFFEL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
NO			215-01-4974			MARVIN STERN			2406 HOUCK MILL RD. MONKTON, MD 21111			1983								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			METASTATIC LUNG CANCER																	
1629																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b)			DUE TO, OR AS A CONSEQUENCE OF														
			(c)			DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-7-84 to 6-7-84, that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			6/7/84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Levinsohn Geriatric Ctr			Baltimore			County			Maryland					
15- Law-Win, MD																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JUNE 10, 1984			23c. NAME OF CEMETERY OR CREMATORIAL BNAI ISRAEL			23d. LOCATION BALTIMORE											
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215												25a. DATE REC'D. BY REGISTRAR JUN 14 1984								

x 20

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and digital noise

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

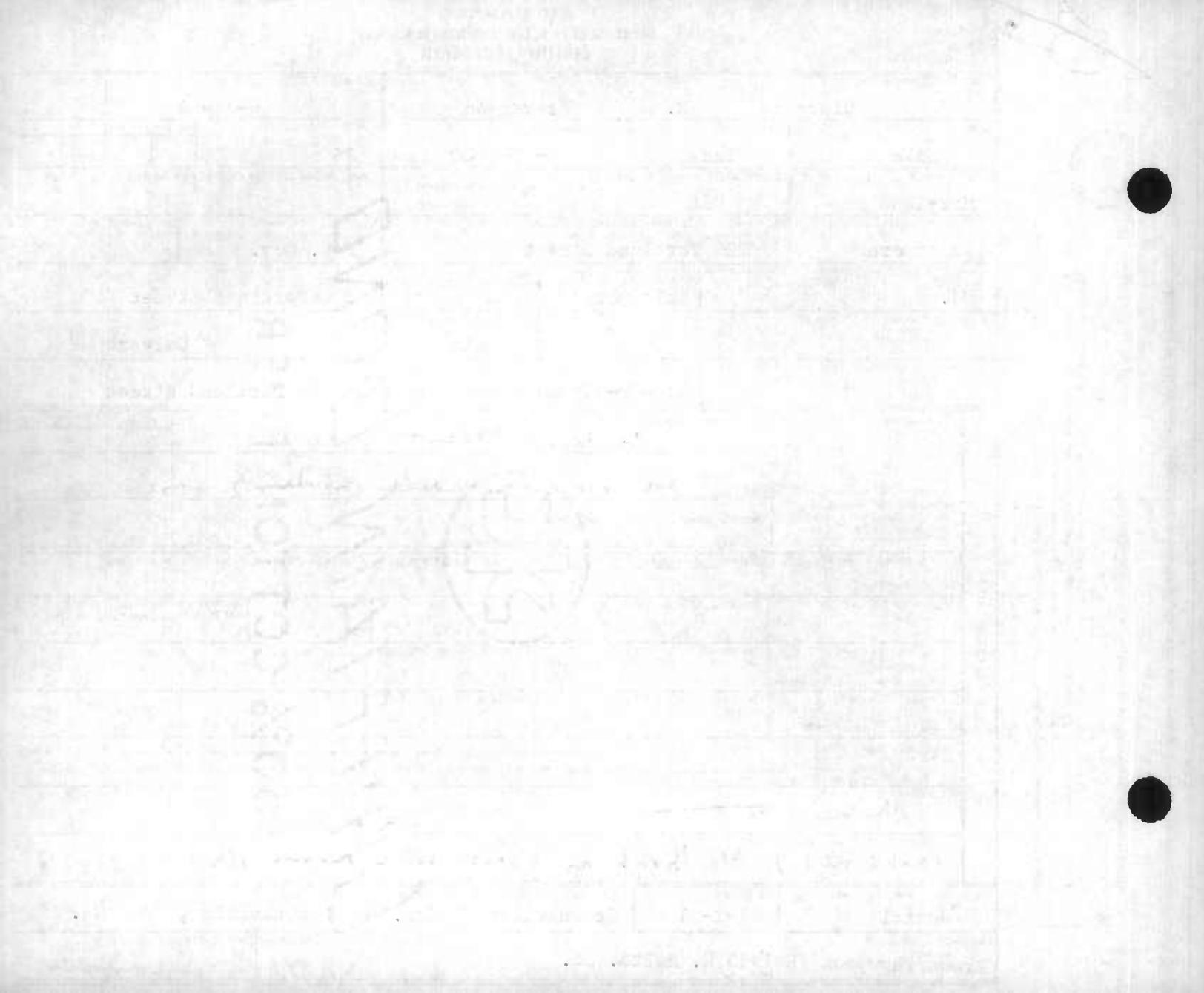
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 34 16327

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Clarence E. Stevenson						6-26-84				M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS	
Male		Black		6-2-1908			76			MONTHS	DAYS
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH City				
Maryland		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		720 Portland Street		Fed. Gov.							
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 720 Portland Street		21230	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME First Lula Middle Calvert Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Irene Stevenson 720 Portland Street		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Cardiac Arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Atherosclerotic Cardiovascular Disease									
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Mohamed J Al- Ibrahim</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21218					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mohamed J Al- Ibrahim		22e. ADDRESS 3900 Coch Runn Blvd									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-2-84		23c. NAME OF CEMETERY OR CREMATORIAL Crownsville VA Cem.		23d. LOCATION CITY OR TOWN Crownsville, COUNTY Md. STATE					
24. FUNERAL DIRECTOR NAME Brown/Thompson FH		ADDRESS 1913 W. Balt St.		25a. DATE REC'D. BY REGISTRAR JUN 29 1984		25b. REGISTRAR'S SIGNATURE Sonia Davidson Rendell					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 3 2 8

REG. NO.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

DE

KNOWN

MONTH

DAY

YEAR

2b. HOUR

EVERNEZER

STEWART

2. SEX

RACE

3. DATE OF BIRTH
MONTH DAY YEAR

6. AGE (IN YEARS
LAST BIRTHDAY)

IF UNDER 1 YR.

IF UNDER 24 HRS.

Female

Black

5

5

15

68

YRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

S. Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Baltimore

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

Maryland

Baltimore

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS

920 Pennsylvania Ave. 3rdf1

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Bosses

Sawyer

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Maggie

Foster

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
(IF YES, GIVE WAR OR DATES)

Unknown

16b. SOCIAL SECURITY NO.

213-14-3919A

17. INFORMANT

ADDRESS

Vastie Jones 3610 Mohawk Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

4029

IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES

NO

21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

Autopsy Inspection Inquiry and in my opinion

ACTUAL
SIGNATURE

M.D. Assistant

TITLE (SPECIFY)
DATE SIGNED 6-7-84

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

111 Penn St., Balto., Md. 21201

ADDRESS

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION

BURIAL

6/13/84

King Memorial Park

CITY OR TOWN COUNTY STATE

Randallstown,

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Wm C March F/H Inc. 1101 E North Avenue

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUN 11 1984

①

John C. Stennis



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16329
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
Willie					Stewart	<input checked="" type="checkbox"/>	6	17	1984			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
male	black	1 5 12	72 yrs.			<input checked="" type="checkbox"/>	6	17	1984	2:32 p.m.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
N. Carolina		U.S.A.					Baltimore City, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		304 E. 20th Street										
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 304 E. 20th Street 21218				
14. FATHER'S NAME FIRST Sylvester		MIDDLE		LAST Stewart		15. MOTHER'S MAIDEN NAME FIRST Mary						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
Yes		241-05-6948		Frances Carr		1436 Stonewood Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Sylvester Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 6/18/84						
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 6/21/84		23c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		23d. LOCATION CITY/TOWN Baltimore,		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR JUN 19 1984		25b. REGISTRAR'S SIGNATURE <i>via Davidson-Korell</i>						
20M 4/B2												

ON THE

REED

CHICAGO



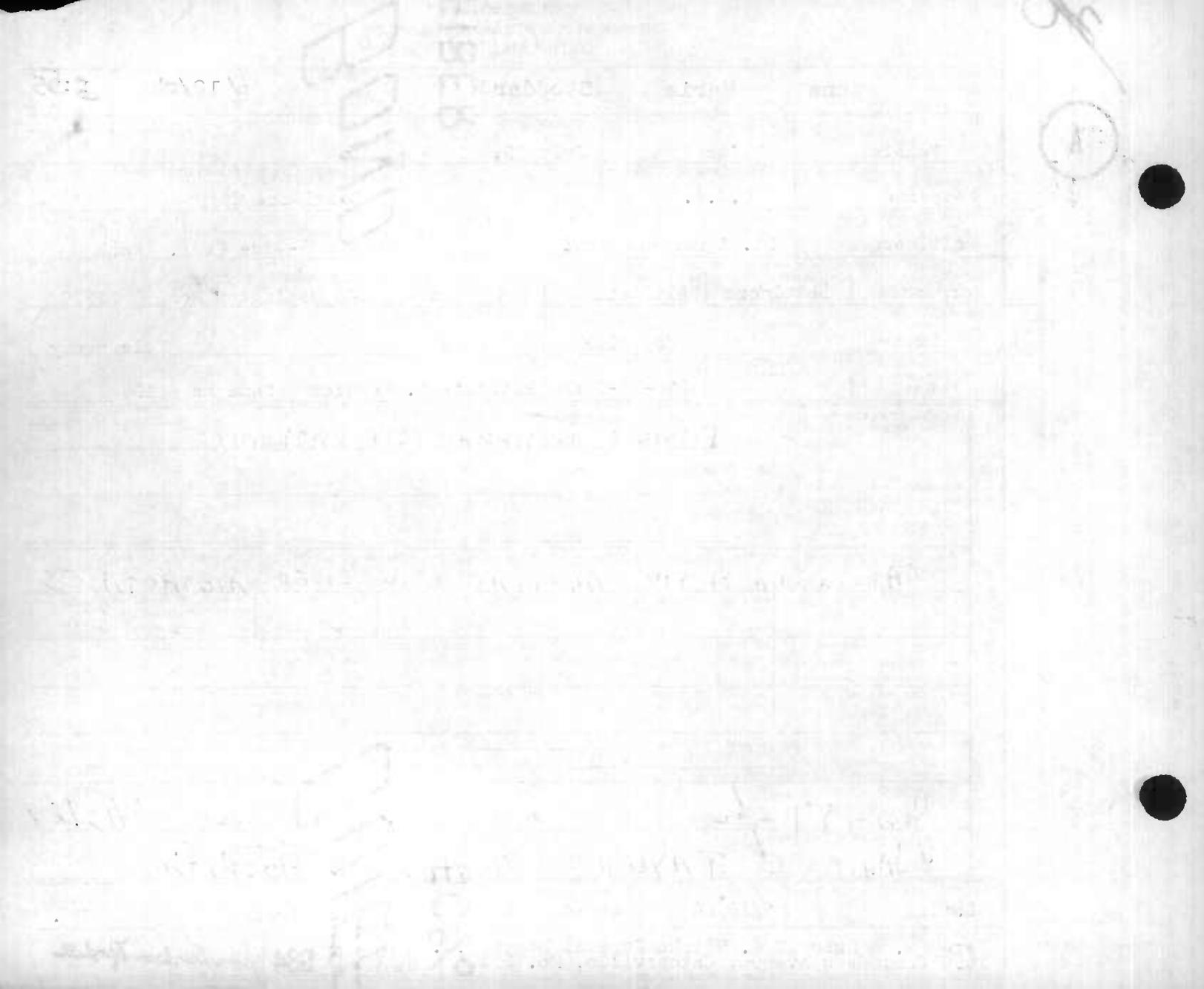
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

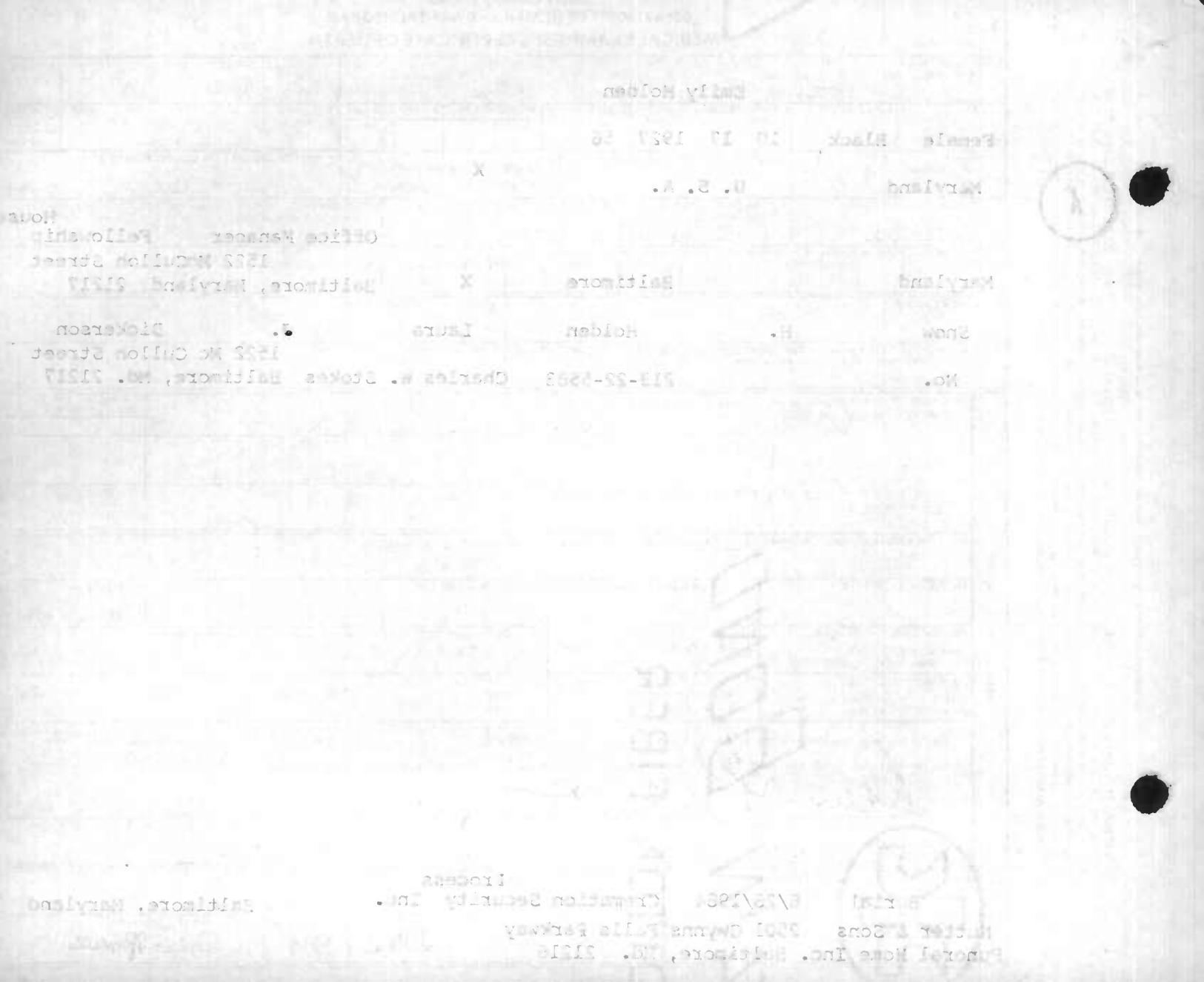
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3416330				
1. DECEASED NAME (TYPE OR PRINT)			FIRST Anne	MIDDLE Marie	LAST Stoddard	2d. DATE OF DEATH MONTH 6		DAY 12	YEAR 1984	2d. HOUR 3:55 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH July			DAY 23	YEAR 1904	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR 79 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Vice Pres. Bank			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 648 Orpington Road 21229						
14. FATHER'S NAME FIRST Henry		MIDDLE 	LAST Kapraklek	15. MOTHER'S MAIDEN NAME FIRST Anna			MIDDLE 	LAST Velenovsky						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-22-7000			17. INFORMANT Patricia M. Koehler		ADDRESS Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLE MULTIFOCAL LEVODYSTROPHY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CARCINOMA OF THE PANCREAS WITH LIVER METASTASES														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f.									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>James S Taylor</i>		22c. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6/13/84									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES S. TAYLOR		22f. ADDRESS ST. AGNES HOSPITAL Baltimore, Md.												
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 6/16/84		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial			23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Md.			23f. STATE Md.		
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR JUN 15 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 3 3 1			
1- STATE REGISTRAR		2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR 6-21 19 84										2b. HOUR 3:07 M			
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-22 19 84		2d. HOUR 3:07 a.m.		
Dorothy Emily Holden Stokes															
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 10 DAY 17 YEAR 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YR. MONTHS		8. IF UNDER 24 HRS. DAYS HOURS MIN		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,			
Maryland		U. S. A.										MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1522 McCulloh Street										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1522 McCulloh Street		12b. KIND OF BUSINESS OR INDUSTRY House Fellowship					
14. FATHER'S NAME Snow		MIDDLE H.		LAST Holden		15. MOTHER'S MAIDEN NAME Laura		J. Dickerson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. No.		16c. DUE TO, OR AS A CONSEQUENCE OF		17. INFORMANT Charles W. Stokes		1522 Mc Culloh Street Baltimore, Md. 21217							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		DATE SIGNED 6-22-84											
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/26/1984		23c. NAME OF CEMETERY OR Process Cremation Security Inc.		23d. LOCATION CITY OR TOWN Baltimore, Maryland		COUNTY		STATE					
24. FUNERAL DIRECTOR Nuttier & Sons Funeral Home Inc.		25a. DATE REC'D. BY REGISTRAR JUN 27 1984		25b. REGISTRAR'S SIGNATURE Davidson Pendell											
25a. DATE REC'D. BY REGISTRAR JUN 27 1984		25b. REGISTRAR'S SIGNATURE Davidson Pendell													
BP _____		DHMH - T7 (VR A15 ME (5)) 20M 4/B2													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of other death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked with an "X" shows only injury, or other traumatic event, the medical certification must be checked.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 16332

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Mary</i>	MIDDLE <i>C.</i>	LAST <i>STOKES</i>	2a. DATE OF DEATH <i>June 27, 1984</i>	MONTH YEAR	DAY	YEAR	2b. HOUR <i>10:30 A</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>2</i>	DAY <i>4</i>	YEAR <i>1920</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>64</i>	YRS	IF UNDER 24 HRS. MONTHS <i>0</i>	DAYS	HOURS <i>0</i>	MIN. <i>0</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>						
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Maryland General Hospital</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>School Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. County</i>			
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Street</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3433 Scarboro Road 21154</i>						
14. FATHER'S NAME FIRST <i>Samuel</i>	MIDDLE <i></i>	LAST <i>Cox</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>		MIDDLE <i></i>	LAST <i>Mordica</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-36-4631</i>	17. INFORMANT <i>John A. Stokes</i>		ADDRESS <i>Same as 13e</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(b) <i>Severe chronic obstructive pulmonary disease</i> 15 years								
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe rheumatiod arthritis</i>			DUE TO, OR AS A CONSEQUENCE OF 20 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Acute gastric ulcer; Diabetes Mellitus.											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (we) attended the deceased from <i>June 19 64</i> , to <i>June 27 19 84</i> , that (we) last saw the deceased alive on <i>June 27 19 84</i> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frederick N. Townshend M.D.</i>	DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>6/27/84</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frederick N. Townshend, M.D.</i>	22e. ADDRESS <i>c/o Maryland General Hospital</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>6/28/1984</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Westview</i>			23d. LOCATION CITY OR TOWN <i>Baltimore</i>	COUNTY	STATE <i>Maryland</i>				
24. FUNERAL DIRECTOR NAME <i>Duda-Ruck, Inc.</i>	AUTHORITY <i>7922 Wise Avenue Dundalk, MD. 21222</i>	25a. DATE REC'D. BY REGISTRAR <i>JUN 29 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 4 6 3 3 5						
1 - FOR STATE REGISTRAR			1. DECEASED NAME FIRST SYLVESTER			MIDDLE STOKES			2a. DATE OF DEATH JUNE 29, 1984			2b. HOUR M						
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 3 DAY 7 YEAR 1929			6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.											
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 728 N. MONROE STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY 21217											
13a. STATE Maryland		13b. COUNTY Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 728 Monroe Street											
14. FATHER'S NAME Walter		FIRST MIDDLE LAST Stokes		15. MOTHER'S MAIDEN NAME N/A			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 245-32 4439			17. INFORMANT Cora Bryant			ADDRESS 812 N. Mount Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Hyper Tensive Cardiovascular disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (the hospital) attended the deceased from <u>May 5</u> , 19 <u>84</u> , to <u>6-28-84</u> , that (we) last saw the deceased alive on <u>May 5</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																		
22b. SIGNATURE <u>Benigno R. Lazaro, MD</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>6-29-84</u>										
22e. ADDRESS <u>1038 Edmondson Ave Baltimore Md 21223</u>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/84		23c. NAME OF CEMETERY OR CREMATORIAL Crownsville Veteran			23d. LOCATION CITY OR TOWN Crownsville COUNTY Md											
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H Inc.</u>		ADDRESS <u>1101 E North Avenue</u>			25a. DATE REC'D. BY REGISTRAR <u>JUL 2 1984</u>			25b. REGISTRAR'S SIGNATURE <u>Maria Davidson-Randall</u>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, it should be detached for use on the burial permit. Then please carbon paper it and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be done.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16334					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Steven					Stokowski	6 3 84						2:15 AM			
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male			Caucasian		Dec 18, 1918		65 RS.			MONTHS DAYS		HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Baltimore Md			U.S.A.						Baltimore City MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR PRINT) Retired			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore			Mercy Hosp.												
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME				
Md			Baltimore		Baltimore		YES <input checked="" type="checkbox"/>		439 S. Cornwall St		Julia Stokowski				
15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Chapek			Yes			21509-8359			B. Brandon			Baltimore			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4151 B. Brandon Pulmonary Emboli														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? pending		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE B. Brandon ms			DEGREE ms			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/3/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Brandon ms			22e. ADDRESS Mercy Hospital, St Paul St Baltimore Md 21202												
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 6-7-84			23c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus			23d. LOCATION Baltimore City Md						
24. FUNERAL DIRECTOR NAME Raymond L. Kaczmarek 2525 Scott			25a. DATE REC'D. BY REGISTRAR JUN 8 1984			25b. REGISTRATION NO. Gina Sundale									
ADDRESS															

20% COTTON

WHEAT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

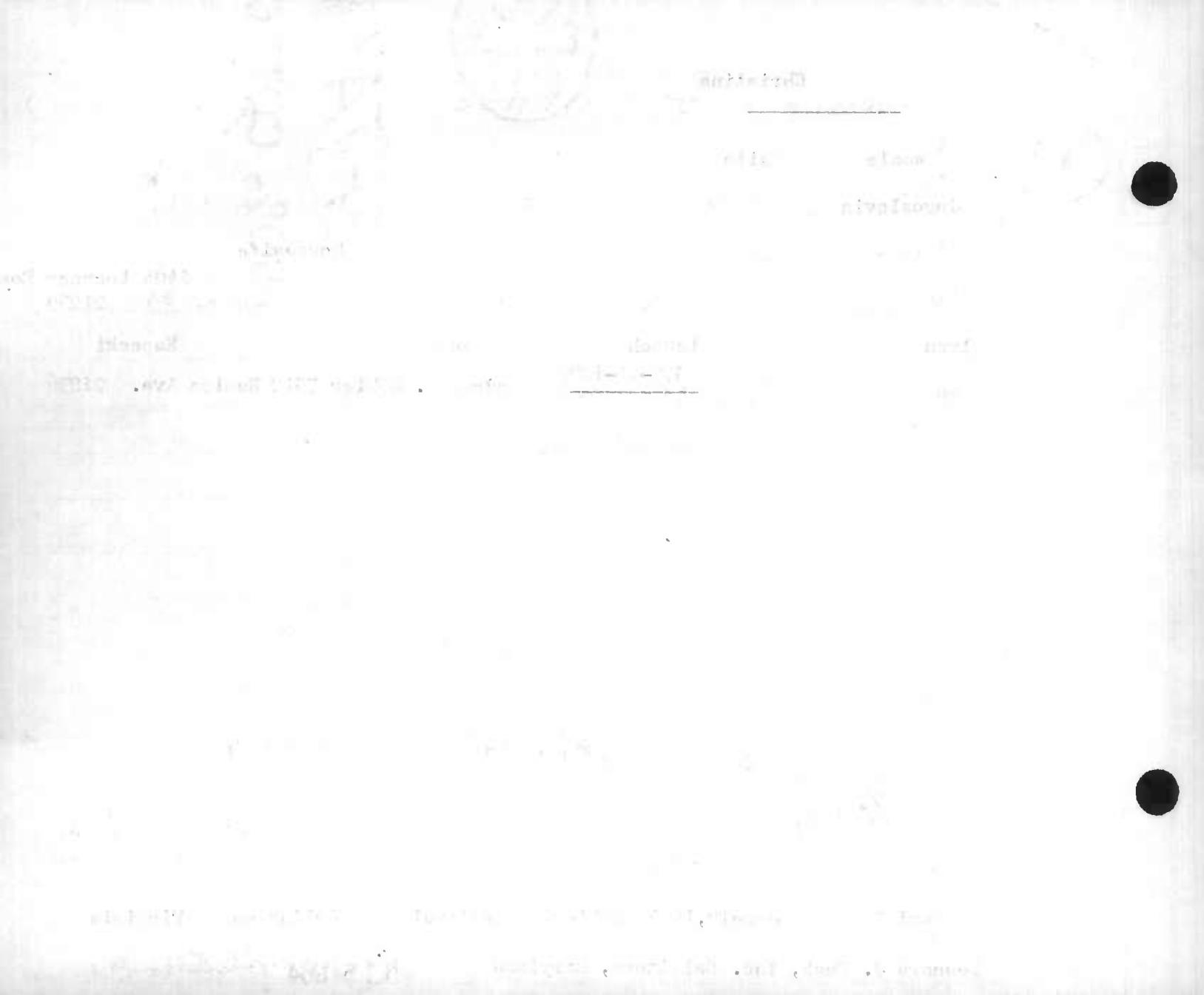
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

4 1 6 3 3 5

1. DECEASED NAME (TYPE OR PRINT)		FIRST Christina MIDDLE J LAST STRAUSS			2a. DATE OF DEATH MONTH DAY YEAR	MONTH DAY YEAR	2b. HOUR	
1. SEX F emale		1. RACE White		5. DATE OF BIRTH MONTH 1 DAY 30 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 . YRS.		
7. PLACE OF BIRTH Jugoslavia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST Ivan		MIDDLE Lenoch		15. MOTHER'S MAIDEN NAME FIRST Ana		13e. STREET ADDRESS / ZIP CODE 1404-C Lochner Rd 21239		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-44-1890		17. INFORMANT ADDRESS Andrew W. Kohler 7512 Kenlea Ave. 21236		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 6/13/84 , 19_____, to 6/13/84 , 19_____, that (I) (we) last saw the deceased alive on 6/13/84 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Leddy		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 6/14	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH B. CODY		22e. ADDRESS Good Samaritan Hospital, Baltimore, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 18, 1984		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN Arlington		COUNTY Virginia
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 15 1984		25b. REGISTRAR'S SIGNATURE Laura Davidson Pendell				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as showing any injury or other traumatic event the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 4 1 6 3 3 6	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 3:35 M	
Fe. Blk.			AGNES C. STREET			8 11 1910			6/19/84				
7a. BIRTHPLACE COUNTY St. Mary Co. Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7c. STATE Md.			7d. CITY OR TOWN Balto.			7e. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7f. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			7g. BALTIMORE CITY OR COUNTY OF DEATH MD.	
10 CITY OR TOWN OF DEATH Balto.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2111 N. Pulaski St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2111 N. Pulaski 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Bernard J. Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary O. Price										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 212 74 3517			17. INFORMANT Mr. Clover Street, Sr. 2111 Pulaski			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 hrs.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			acute Renal Failure										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pyelonephritis									8-10 yrs	
			DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Bladder									2-4 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: Hypertensive Cardiovascular Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE James D. Solomon, M.D.			DEGREE						22c. DATE SIGNED 6-19-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James D. Solomon, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 2339 W. North Ave., Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/23/84			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn			23d. LOCATION CITY OR TOWN Baltimore, Md. COUNTY STATE				
24 FUNERAL DIRECTOR NAME Jas. A. Morton & Sons			ADDRESS 1701 Laurens			25a. DATE OF BURIAL OR Cremation JUN 20 1984			25b. REGISTRATION NUMBER 100				

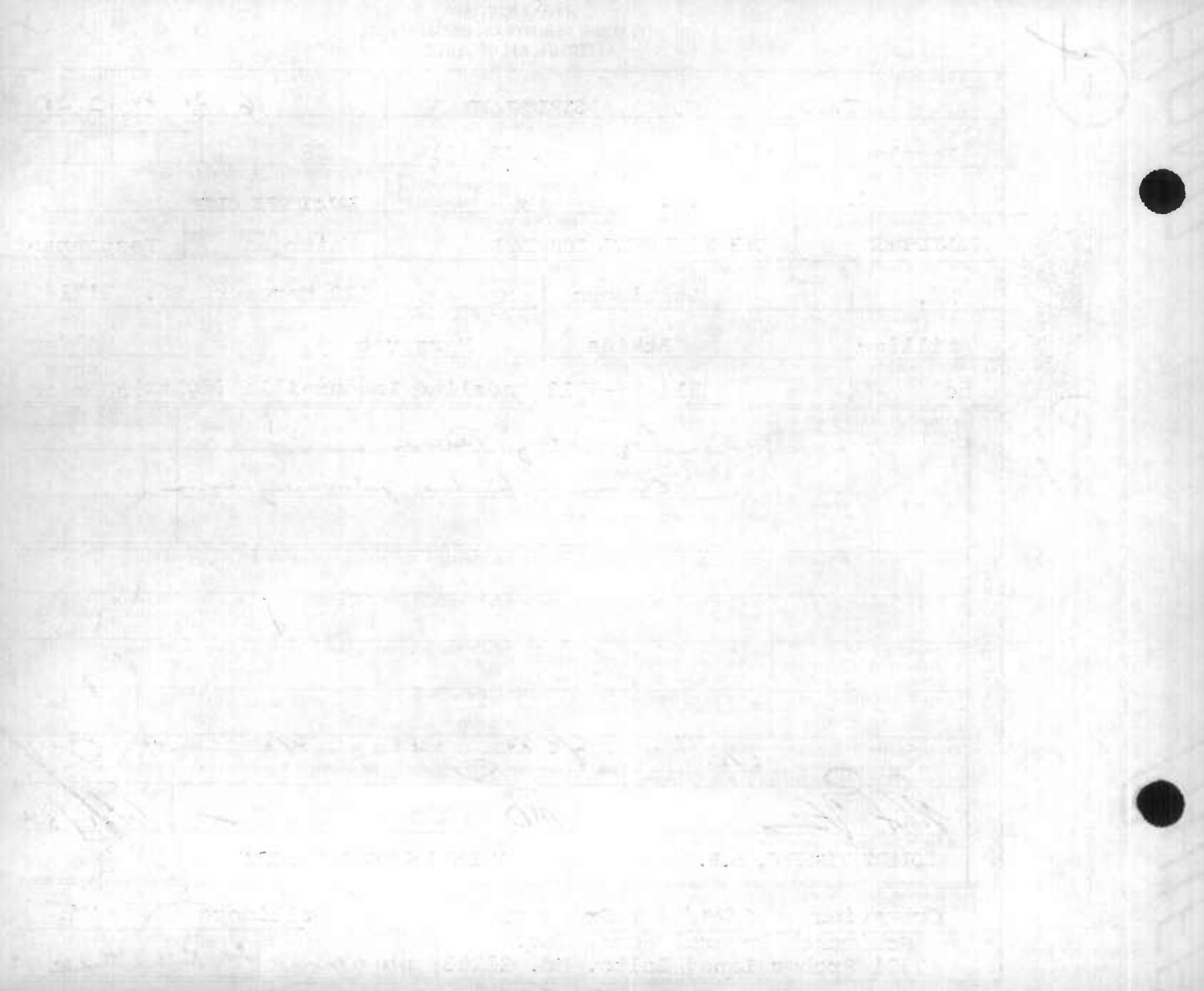
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3416337	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR P 2:28 M	
I. DECEASED NAME FIRST MIDDLE LAST				STRICKLAND							
EILEEN W.											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
				Aug. 13 1918				65 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4423 Harcourt Rd. 21214			
14. FATHER'S NAME FIRST William		MIDDLE Atkins		LAST		15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE		LAST Holden	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-14-5712		17. INFORMANT Madeline Lapouraille (dghtr)		ADDRESS same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive pulmonary disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/21/84, 19 88, to 6/21, 19 88, that (I) (we) lost saw the deceased alive on 6/21, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE ROBERT VISSING, M.D.		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/21/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT VISSING, M.D.		22e. ADDRESS UNION MEMORIAL HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/22/84		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount		23d. LOCATION CITY OR TOWN Baltimore		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane, Balt. Md. 21213		25a. DATE REC'D. BY REGISTRAR 11/11/22 1001		25b. REGISTRAR'S SIGNATURE Schimunek Mandell							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 4 1 6 3 3 8											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR		
			John Strong						June 13, 1984		
M											
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			21. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		
Male			Black			9 - 15 - 1905			78 YRS. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.		
N. Carolina			U.S.A.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			Greater Pennsylvania N/H						Apt. 1404 21201		
13a. STATE Maryland			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1102 Druid Hill Avenue		
14. FATHER'S NAME Lee			15. MOTHER'S MAIDEN NAME Strong			16. SOCIAL SECURITY NO. 213-07-2090			17. INFORMANT ADDRESS Sallie Strong 1102 Druid Hill Avenue Apt. 1404		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH May years		
NO						DUE TO, OR AS A CONSEQUENCE OF (b)					
						DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a COPD, CVA & @ Hemiparesis, Diabetes Mellitus, PVD, septicemia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-16-1984 to 6-13-1984, that (I) (we) last saw the deceased alive on 6-13-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Shaukat Y. Khan			M.D. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-14-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAUKAT Y. KHAN			22e. ADDRESS 1528 King William Drive, Baltimore, MD.								
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 6/19/84			23c. NAME OF CEMETERY OR CREMATORIAL Mount Calvary Cem.			23d. LOCATION Arundel Co., Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/I Inc. 1101 E North Avenue			ADDRESS			25a. DATE REC'D. BY REGISTAR JUN 15 1984			25b. REGISTAR'S SIGNATURE Davidson Pendell		

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The retained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been issued, it should be detached from the burial-transit permit and sent to the State Dept. of Health and Mental Hygiene.

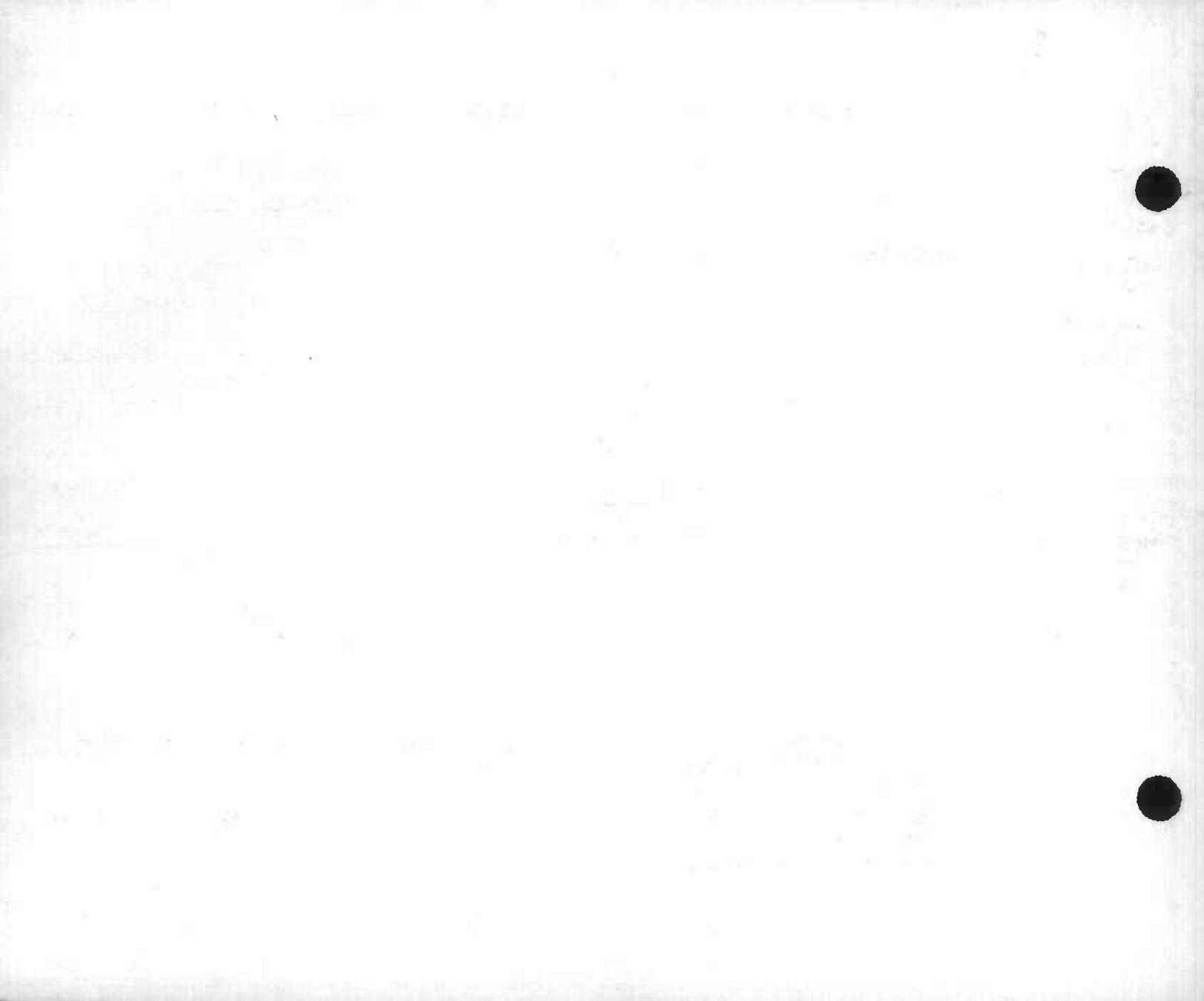
MEDICAL CERTIFICATION

**1 - STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE OF DEATH	MONTH	DAY	YEAR	HOUR	
GEORGE Chester STULL						JUNE 25, 1984				7:07AM	
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR				
Male	White	Feb. 13, 1895				89 yrs.	MONTHS	DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.					BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	JOHNS HOPKINS HOSPITAL					Blacksmith					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Thurmont	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. ADDRESS 6727 Mountaintdale Rd/21788				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Thomas Michael Stull			Minnie Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. WWI	17. INFORMANT	ADDRESS 10632 Powell Road, Thurmont, Md. 21788								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>My stroke</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mins.</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe stroke</u>									<u>10 days</u>		
(c) <u>Severe hemolytic anemia</u>									<u>12 days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 16, 1984</u> , to <u>June 25, 1984</u> , that (I) (we) last saw the deceased alive on <u>June 25, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>SCOT Remick</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>6/25/84</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SCOT REMICK</u>	22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <u>6/28/84</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Utica Cemetery</u>	23d. LOCATION CITY OR TOWN <u>Frederick</u>	23e. COUNTY <u>Md.</u>	23f. STATE <u>MARYLAND</u>						
24. FUNERAL DIRECTOR NAME <u>G. Douglas Stauffer</u>	25a. DATE REC'D. BY REGISTRAR <u>JUL 2 1984</u>	25b. REGISTRAR'S SIGNATURE <u>John DeLorain Pendell</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon paper. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed within 72 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 6 3 4 0					
										REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR
		WILLIS							SUMPTER		05	08	84	10 25	
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M		B			MONTH DAY YEAR			45			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH							
BALTO., MD.		USA			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			BALTIMORE			City		MD.		
8. MARRIED		9. DIVORCED													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION)			12a. USUAL OCCUPATION (TYPE OF OCCUPATION OR TRADE)			12b. KIND OF BUSINESS OR INDUSTRY							
BALTO.		MERCY HOSPITAL			PARKS SAUSAGE										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?					
13a. STATE MD.		13b. COUNTY BALTO.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. STREET ADDRESS 5441 PRICE AVE.							
14. FATHER'S NAME JOSEPH		15. MOTHER'S MAIDEN NAME SYLVIA			FIRST		MIDDLE		LAST		GREEN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 219-32-9137			17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO					SHIRLEY SUMPTER		5441 PRICE AVE.						5 years		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic renal cell ca</u>															
1890 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										months					
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>renal failure</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> , 19 <u>84</u> , to <u>6-8</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <u>Jeanne Saunders MD</u>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED <u>6-8-84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jeanne Saunders</u>		22e. ADDRESS <u>Mercy Hosp. Jr.</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/184			23c. NAME OF CEMETERY OR CREMATORIUM MARYLAND NAT. MEM. PK.		23d. LOCATION LAUREL, MD.		COUNTY		STATE				
24. FUNERAL DIRECTOR LERoy O. DYETT & SON		4600 LIBERTY HTGS. AVE.			25a. DATE RECEIVED BY REGISTRAR JUN 12 1984		25b. REGISTRAR'S SIGNATURE <u>Jeanne Saunders</u>								
BP_____															
DHMH - 16 50M 4/B2 (VRA 15, 4)															

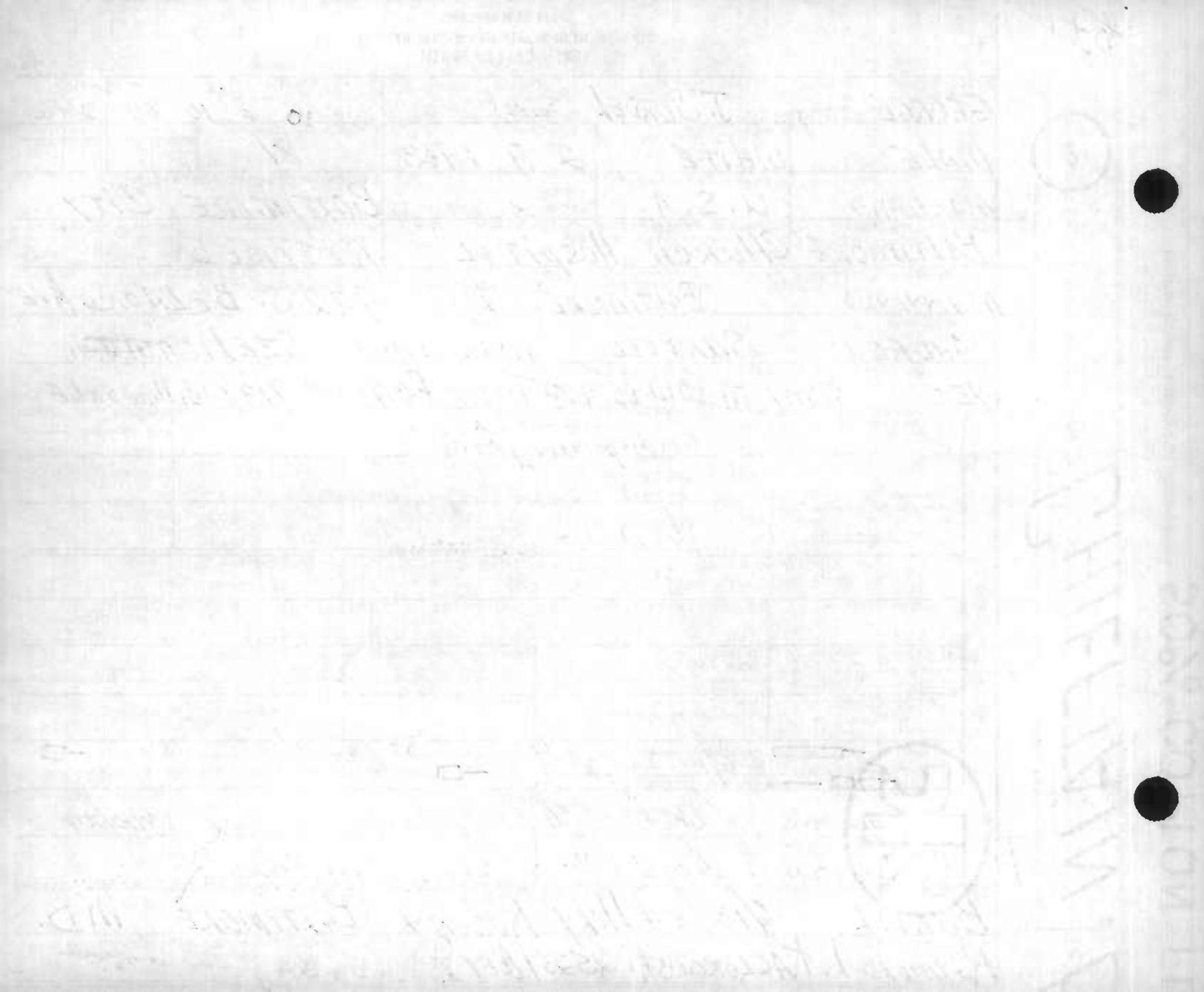
104 - MARKETING UNIT
BURIAL OF JUNIOR S. KEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 4 16341 2:37am	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH 1984			MONTH DAY YEAR	2d. HOUR 227AM			
GEORGE George J. SURDEL			GEORGE	J. SURDEL		June 10, 1984			6 10 84				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 29 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City			MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY 21201						
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 922 S. BELNORD AVE							
14. FATHER'S NAME FIRST ANDREW		MIDDLE SURDELL		15. MOTHER'S MAIDEN NAME FIRST MARYANNE SZELIGA		16b. SOCIAL SECURITY NO. ARMY II 214 05 3153			17. INFORMANT TILLIE FRITSCH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/>		16b. SOCIAL SECURITY NO. 214 05 3153		17. INFORMANT TILLIE FRITSCH			ADDRESS 7138 Willowdale				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest													
DUE TO, OR AS A CONSEQUENCE OF (b) Sepst Sepsis													
DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration Dehydration													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
22a. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET CITY OR TOWN COUNTY STATE							
22d. I certify that <input type="checkbox"/> attended the deceased from June 10, 1984 to 10 , 1984, that <input type="checkbox"/> was last seen alive on June 10, 1984 , and that in <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> did <input type="checkbox"/> view the body after death.													
22e. SIGNATURE Lawrence J. Appel			22f. DEGREE M.D.			22g. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22h. DATE SIGNED 6/13/84				
22i. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence J. Appel			22j. ADDRESS Church Home Hospital 100 N. Baltimore, Md. 21231 Broadway										
23a. FUNERAL CREMATION REMOVAL BURIAL			23b. DATE 6/13/84			23c. NAME OF CEMETERY OR CREMATORIUM Holy Rosary			23d. LOCATION Baltimore, MD.		23e. COUNTY Baltimore		
24. FUNERAL DIRECTOR NAME Raymond L. Kaczorowski			ADDRESS 2525 Fleet St.			25a. DATE REC'D. BY REGISTRAR JUN 14 1984			25b. REGISTRAR'S SIGNATURE ...murdison-kendall				

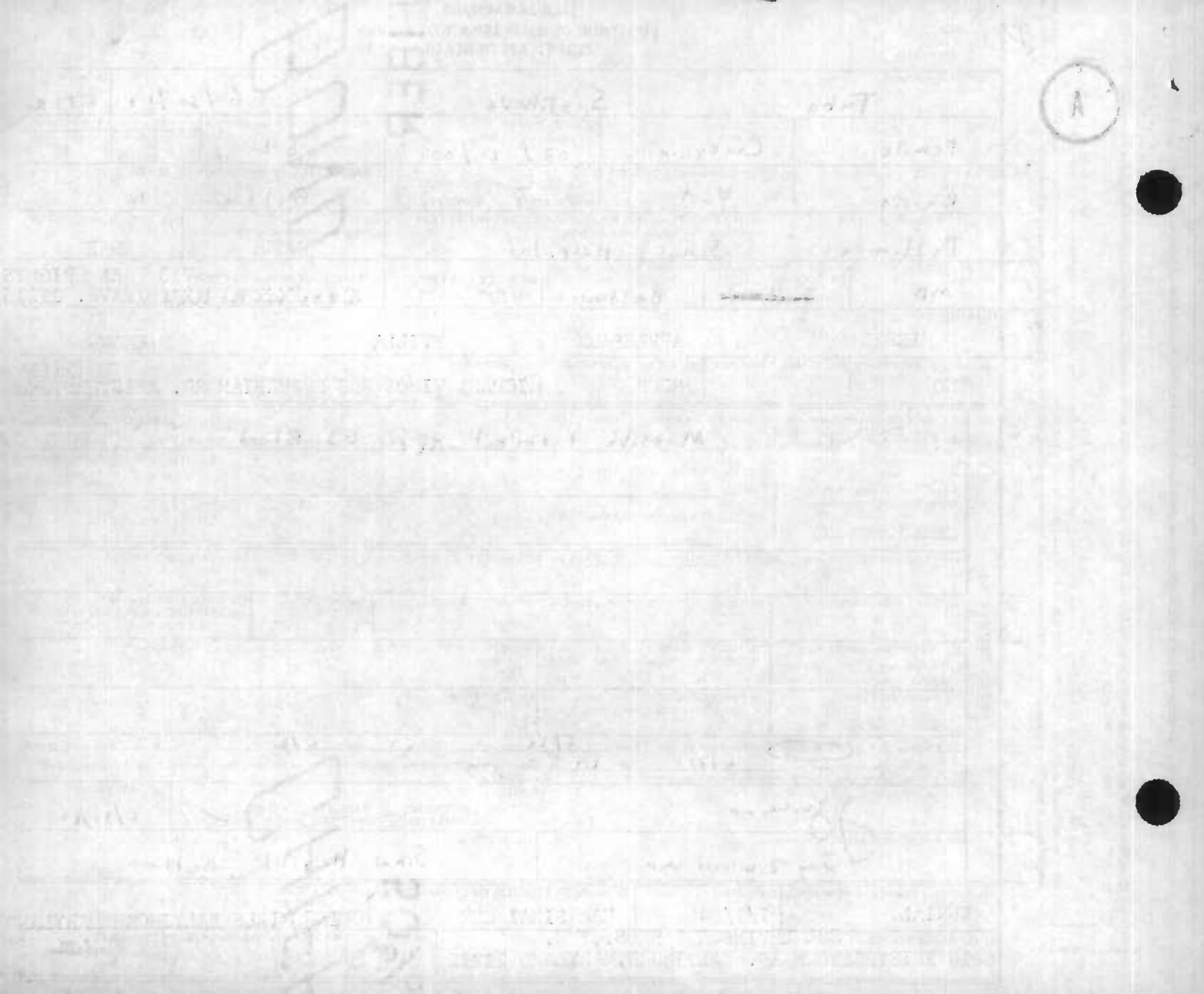


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 6 3 4 2			
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR		
			Tuba			Suslikova			6/30/84			6/37 AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			Caucasian			MONTH DAY YEAR			84			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Russia			USA						Baltimore City						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore			Sinai Hospital			NONE			NONE						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD			Baltimore			Baltimore						5715 PARK HEIGHTS AVE. 21215			
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME									
FIRST NISSEL			MIDDLE			FIRST TVILLA			MIDDLE			LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE terminal upper GI Bleed			ADDRESS			
NO			NONE			MICHAEL VINOS 805 SUBURBAN RD. REISTERSTOWN MD 21136									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <u>this hospital</u> attended the deceased from 6/28/84 to 6/30/84, that (I) <u>was</u> lost saw the deceased alive on 6/30/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>J. Zweier MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 6/30/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jay Zweier MD</i>			22e. ADDRESS Sinai Hospital, Baltimore												
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 7/1/84			23c. NAME OF CEMETERY OR CREMATORIAL HAR SINAI CEM			23d. LOCATION CITY OR TOWN OWINGS MILLS BALTIMORE MARYLAND			COUNTY STATE			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215						25a. DATE REC'D. BY REGISTRAR JUL 6 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If Item 21 is marked "No,"

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 4 1 6 3 4 3			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR
Joseph					Susnosky	06 05 84							2:14 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH 01	DAY 24	YEAR 07	77 YRS.		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Midtown Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5610 Woodmont Ave. Apt. B 21239				
14. FATHER'S NAME FIRST Charles		MIDDLE Susnosky	LAST	15. MOTHER'S MAIDEN NAME FIRST Pauline			MIDDLE	LAST Sagatowicz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. 214-26-8714		17. INFORMANT Helen Piccholie			ADDRESS Peckville Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible Myocardial Infarction</u> (b) _____ (c) <u>Ascert</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 12/20			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>06/05</u> , 19 <u>84</u> , to <u>06/05</u> , 19 <u>84</u> , that (II) (we) last saw the deceased alive on <u>06/05</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Ashik K Chatterjee</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2027		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ashik K Chatterjee</u>		22e. ADDRESS 3527 Annapolis Court											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/8/84		23c. NAME OF CEMETERY OR CREMATORIUM Church Cem.			23d. LOCATION CITY OR TOWN Eynon,		COUNTY		STATE Pa.		
24. FUNERAL DIRECTOR NAME Wm C March F/H, Inc.		25a. DATE REC'D. BY REGISTRAR 1101 E. North Ave JUN 6 1984			25b. REGISTRAR'S SIGNATURE Lisa Davidson Pendell								

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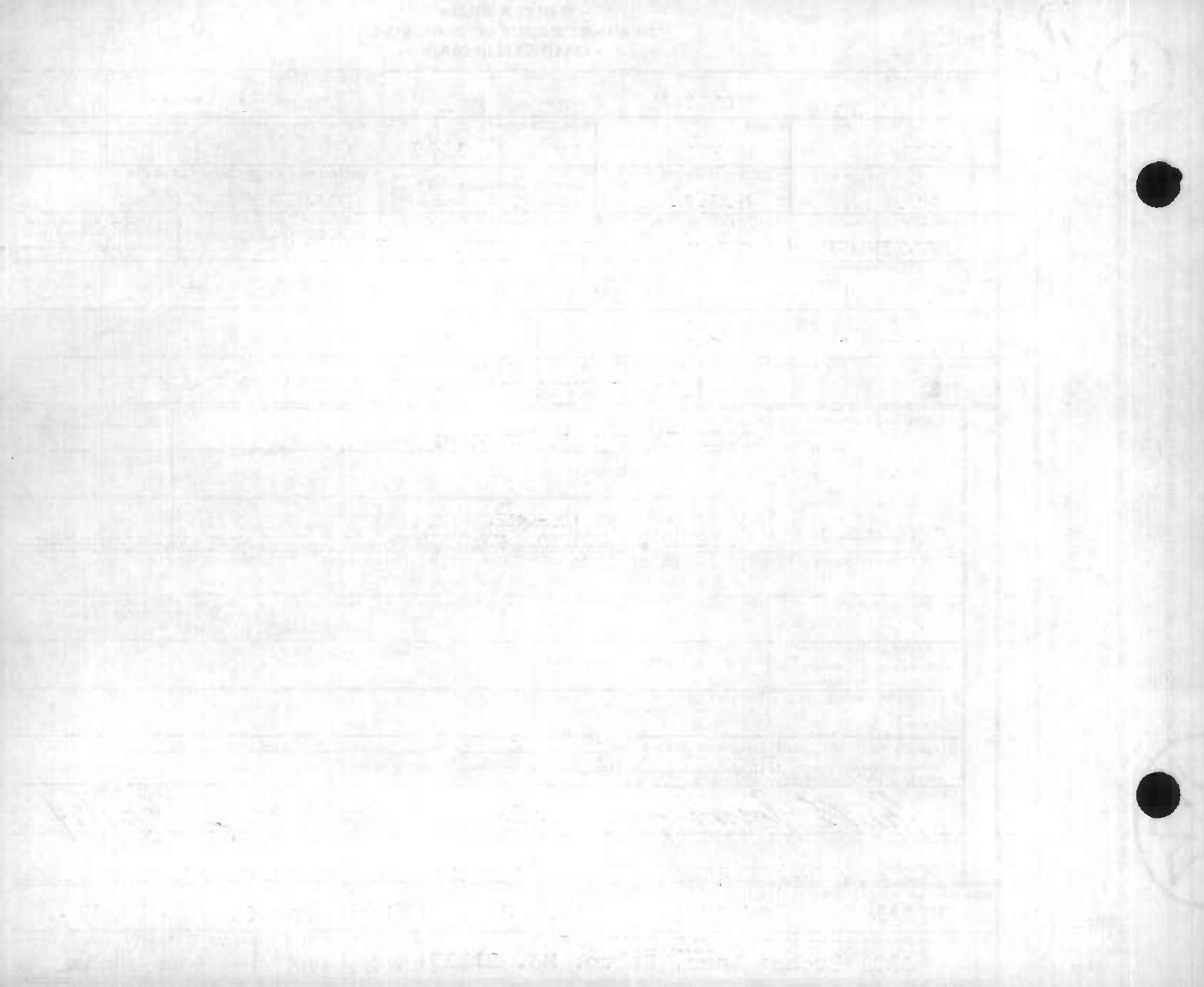
87 100 20 60 11
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B TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or hem 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												4	1	6	3	4	4			
1. FOR STATE REGISTRAR															REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
JOHN WILLIAM SWANN SR.						JUNE 21, 1984						8:00 P.M.								
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH APRIL 9, 1915			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 69								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			IF UNDER 1 YEAR MONTHS DAYS								
10 CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL CORP.												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPPLY OFFICER			12b. KIND OF BUSINESS OR INDUSTRY DISASTER CONTROL CENTER		
13a. STATE MD.			13b. COUNTY -			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3205 McELDERRY ST. 21205								
14. FATHER'S NAME FIRST GEORGE			MIDDLE SWANN	LAST	15. MOTHER'S MAIDEN NAME FIRST ELIZABETH			MIDDLE	16. ADDRESS HUNT											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 312-07-6724			17. INFORMANT RUTH SWANN (WIFE)			ADDRESS SAME ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: ADENOCARCINOMA OF LUNG															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF																				
DUE TO, OR AS A CONSEQUENCE OF CHRONIC OBSTRUCTIVE LUNG DISEASE, UPPER EXTRAMAGASTROINTESTINAL BLEEDING																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) XX			21f. LOCATION STREET JUNE 14 84			CITY OR TOWN CITY OR TOWN			COUNTY COUNTY			STATE STATE					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 14 84 , to JUNE 21 1984 , that (I/we) last saw the deceased alive on JUNE 21 1984 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.																				
22b. SIGNATURE <i>Paul E. Gormley</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. ADDRESS CHURCH HOSPITAL			22f. DATE SIGNED <i>6/21/84</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL E. GORMLEY			22e. ADDRESS 100 NO NORTH BROADWAY 21231			23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 6/25/84			23c. NAME OF CEMETERY OR CREMATORIAL BELAIR MEM. GARDENS			23d. LOCATION CITY OR TOWN BALTO.					
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Baltó. Md. 21213			24a. DATE REC'D. BY REGISTRAR JUN 22 1984			24b. REGISTRAR'S SIGNATURE <i>Sophia Davidson Pendelle</i>														



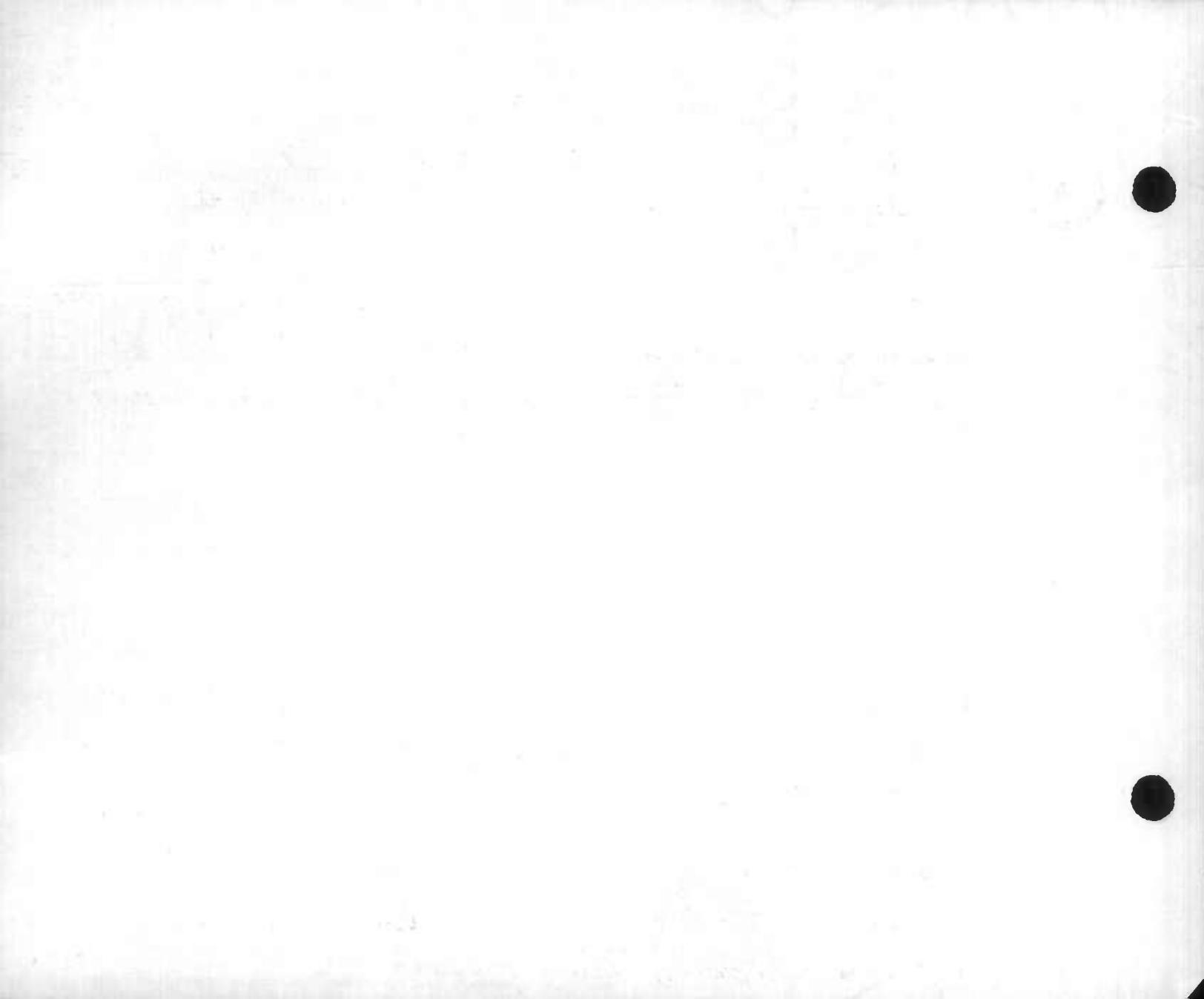
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

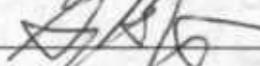
IMPORTANT: If Item 21 is marked in Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6 345			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			6 29 84							3:30 a	
GEORGE WILLIAM SWEENEY													
3. SEX Male		4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.			IF UNDER 1 YEAR MONTHS DAYS		
					7-22-1924								
7. BIRTHPLACE STATE OR FOREIGN COUNTRY		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE city MD.			10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VAMC BALTIMORE, MARYLAND 21218		
Massachusetts		U.S.A.			12a. USUAL OCCUPATION Microbiologist Univ. Hosp.			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 837 Hollins St. 21201				
14. FATHER'S NAME First Middle Last		George A. Sweeney			15. MOTHER'S MAIDEN NAME Mary J. Keough			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 1942-1962			16b. SOCIAL SECURITY NO. 027 16 6531		
								17. INFORMANT Judith Dr. Collins 1333 Sargent St.			ADDRESS 21223		
4. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a))													
DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal varicole bleeding													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholism													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, ANOTHER MEDICAL ARRANGER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
22a. INJURY OCCURRED HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22d. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 14 19 84 to JUNE 29 19 84, that in my (<input checked="" type="checkbox"/>) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did (did) (did) <input type="checkbox"/> (see) the body after death.													
22e. SIGNATURE Thuy v. Nguyen MD.			22f. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22g. DATE SIGNED 6/29/84				
22h. PHYSICIAN'S NAME (TYPE OR PRINT) Thuy v. Nguyen MD.			22i. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218										
23a. BURIAL, CREMATION, REMOVAL CASKET			23b. DATE 7-2-1984			23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cen.			23d. LOCATION CITY OR TOWN Owings Mills Balt. Co. Md.				
24. FUNERAL DIRECTOR NAME John J. Cowan Jr. Jr. 901 Hollins St.			ADDRESS Baltimore 21223			25a. DATE RECEIVED BY REGISTRAR/ASSISTANT REGISTRAR JUL 03 1984			25b. PLACE RECEIVED BY REGISTRAR/ASSISTANT REGISTRAR Garrison Forest				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16346			
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6/17/84 19									2b. HOUR M			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Christopher			MIDDLE D.			LAST Swoboda			2c. DATE PRONOUNCED DEAD 6/17/84 19			2d. HOUR 2:33 A.M.
SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				
Male		White	March 6, 1984		YRS. 3 11										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			
Maryland			U.S.A.												
11. ID CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A			
13a. STATE Maryland			13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 631 Charraway Road 21229			12b. KIND OF BUSINESS OR INDUSTRY N/A		
14. FATHER'S NAME Daniel			MIDDLE			LAST Swoboda			15. MOTHER'S MAIDEN NAME FIRST Kathryn			MIDDLE LAST Kase			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Daniel Swoboda			ADDRESS Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (o)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
ACTUAL SIGNATURE 														DATE SIGNED 6/17/84	
EXAMINER'S NAME (TYPE OR PRINT)			Gregory R. Kauffman, M.D. ADDRESS 111 Penn St., Balto., Md. 21201												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6/20/84			23c. NAME OF CEMETERY OR CREMATORIAL Lakeview Memorial Park			23d. LOCATION CITY OR TOWN Sykesville			COUNTY Carroll	STATE Md.		
Burial															
24. FUNERAL DIRECTOR Gregory M. & Russell C. Witzke Funeral Homes P.A.			25a. DATE REC'D. BY REGISTRAR 1630 Edmondson Avenue, Catonsville, Md. 21228 JUN 19 1984											25b. REGISTRAR'S SIGNATURE 	
BP			DHMH - 17 (VR A15 ME (5)) 20M 4/82												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

Item 4 per ph. 6/27/84 kg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3416341

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOEL	MIDDLE T.	LAST SYKES	2a. DATE OF DEATH MONTH 06	DAY 17	YEAR 84	2b. HOUR 6:15 PM			
3. SEX m			4. RACE White			5. DATE OF BIRTH MONTH 9			DAY 8	YEAR 26		
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED XXX WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.			
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor			12b. KIND OF BUSINESS OR INDUSTRY Plant			
13a. STATE Maryland			13c. CITY OR TOWN CARROLL			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO XXX			13e. STREET ADDRESS / ZIP CODE 1555 Wesley Road 21048			
14. FATHER'S NAME FIRST CHARLES			MIDDLE J.	LAST SYKES	15. MOTHER'S MAIDEN NAME FIRST SUSAN			MIDDLE E.	LAST WALSH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. KOREA 220-18-3330			17. INFORMANT Mrs. Maurie Stephan			ADDRESS 1555 Wesley Rd Finksburg, Md 21048			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Brain tumor Cardiomyopathy Arrest												
DUE TO, OR AS A CONSEQUENCE OF (b) Brain tumor (Probably glioblastoma)												
DUE TO, OR AS A CONSEQUENCE OF (c) M. H. forme												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6/17/84 to 6/13/84 , to 6/13/84 , that (I) (we) did not see the deceased alive on 6/17/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE Francis J Ferraro			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> Hause			22d. DATE SIGNED 6/17/84			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 6-20-84			23c. NAME OF CEMETERY OR CREMATORIAL PATAPSCO			23d. LOCATION CITY OR TOWN PATAPSCO CEMETRY			
24. FUNERAL DIRECTOR Robert Job Pritchett			25a. DATE REC'D. BY REGISTRAR JUN 22 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Renfrew			STATE Md			
NAME Robert Job Pritchett			ADDRESS Westminster, Md									

48 51 30

23X2 8 100T

13

32 8 9

100C

13

132 33-116

12.11

40

Tank 2000
1000 cu ft
each tank 2221 cu ft
approximate tank
size 1000 cu ft

1000 cu ft
each tank approx
1000 cu ft
each tank
(approx)

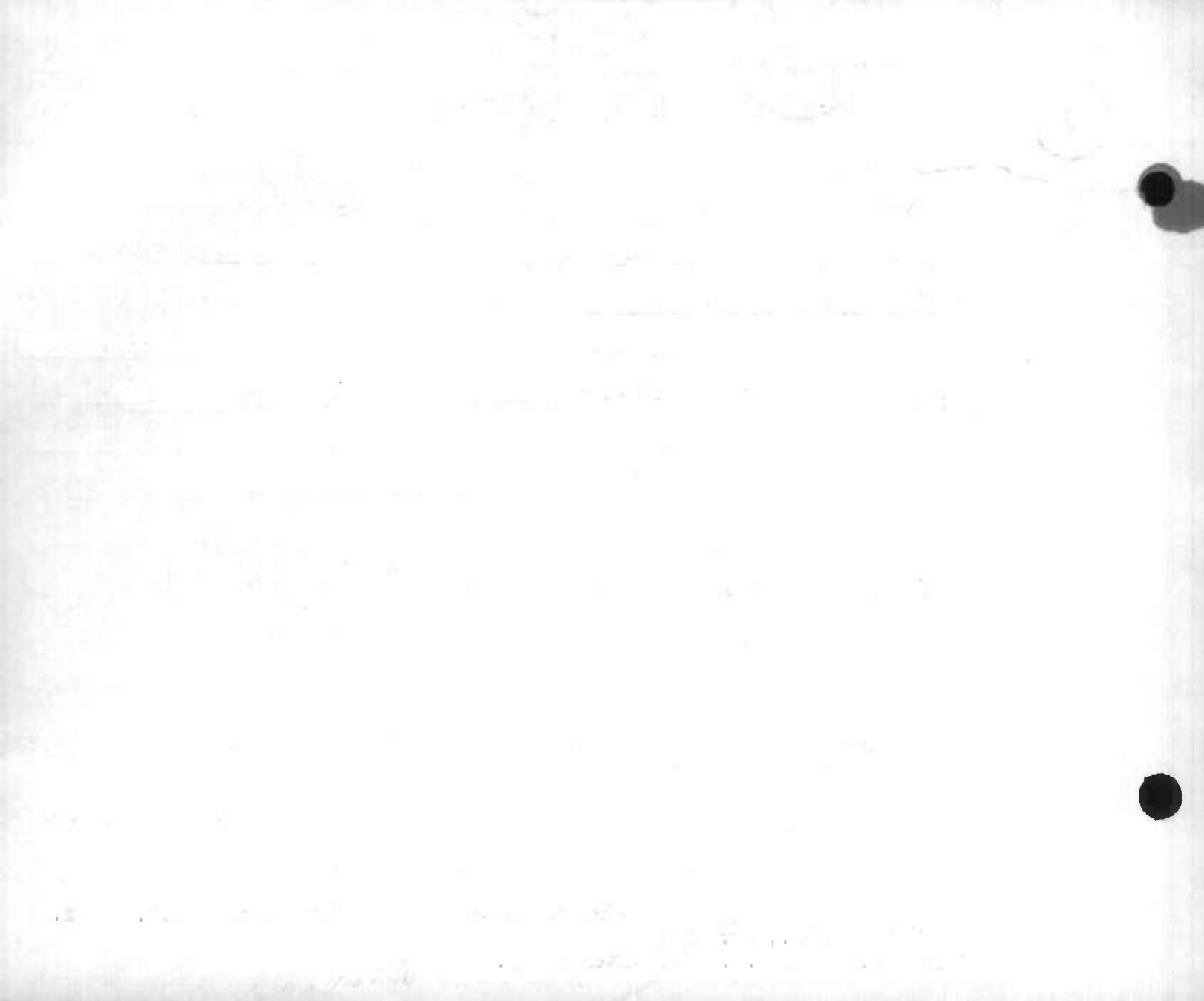
0 2000 cu ft
each tank
approximate
size 1000 cu ft
each tank
approximate
size 1000 cu ft

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, a medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 4 1 6 3 4 8		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
AKA WALTER			WLAUDYLOW	D.	SZYMKOW	6 7 84						10 ³² AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		CAUC.		MONTH	DAY	YEAR	74			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
YA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		South Baltimore Gen Hosp		SELF-EMPLOYED			GARAGE							
13a. STATE MD		13b. COUNTY AA.		13c. CITY OR TOWN BROOKLYN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 214 Southenly Rd 21225				
14. FATHER'S NAME FIRST Michael		MIDDLE		15. MOTHER'S MAIDEN NAME LAST Szymbow			16. SOCIAL SECURITY NO. 224 16 3553			17. INFORMANT Emelia				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. IMMEDIATE CAUSE (a) WW II		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4960			17. INFORMANT ADDRESS ALVERTA SZYMROW (SAME AS 13c)							
				DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Failure</u>										
				DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u>										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>84</u> , to <u>June 7</u> , 19 <u>84</u> , that (I/we) last saw the deceased alive on <u>June 7</u> , 19 <u>84</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Robert J. Neinfeld		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Neinfeld		22e. ADDRESS South Baltimore Gen Hosp.		22f. DATE SIGNED 6/7/84										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Balto., Md. 21225		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial			23d. LOCATION CITY OR TOWN Glen Burnie			COUNTY A.A.			STATE Md.	
24. FUNERAL DIRECTOR GEORGE J. GONCE F.H. 4001 ADAMS Ritchie Hwy.							25a. DATE REC'D. BY REGISTRAR Jun 8 1984						25b. REGISTRAR'S SIGNATURE JUN 8 1984	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 4 6 3 4 9			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 6 24 84									2b. HOUR 9 05 PM			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Frances E			MIDDLE Tallen									
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 2, 1899			6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker			12b. KIND OF BUSINESS OR INDUSTRY -----						
13a. STATE Maryland			13b. COUNTY -----			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3718 Raspe Avenue 21206			
14. FATHER'S NAME FIRST John			MIDDLE Ryan			LAST			15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Buchanen LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-18-8155			17. INFORMANT Theresa McSweeney			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) CHT												
			DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6/24/84 to 6/24/84, that (I) (we) lost saw the deceased alive on 6/24/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE DAVID S. DUNN			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/24/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID S. DUNN						22e. ADDRESS 201 E. UNIVERSITY PKWY									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 27, 84			23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY STATE			
24. FUNERAL DIRECTOR NAME Dipper Funeral Homes, Inc. ADDRESS 7110 Belair Road Baltimore, Md.															25. DATE REC'D. BY REGISTRAR'S SIGNATURE JUN 26 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be searched within 24 hours after death.

Page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-troupe permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hyg. and prior to burial, examination or removal.

IMPORTANT: If Item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 5 0					
												REG. NO.					
1 - FOR STATE REGISTRAR			Russell Tallman														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST						2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 46					
Tallman			Russell						6 11 84			5 P.M.					
3. SEX M ale			RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
						6 5 21			63 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City								
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman-American Standard			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1621 Manor Rd 21222					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
John Tallman						Allie SHEETS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT Rose G. Tallman			ADDRESS Same as 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiogenic/monitory arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) cardiac failure																	
{ DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION 4/19/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery dx, ventriculotomy			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 418			21f. LOCATION STREET 418			CITY OR TOWN 5th			COUNTY 19			STATE 84		
22a. I certify that (I) (this hospital) attended the deceased from 4/18 , 19 84 , to 4/18 , 19 84 , that (I) (we) last saw the deceased alive on 4/18 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.																	
22b. SIGNATURE <i>Melvin J. Duckett, M.D.</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6/11/84								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Duckett, M.D.			22f. ADDRESS University of Maryland Hospital														
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial			23b. DATE 6/15/1984			23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn			23d. LOCATION CITY OR TOWN Baltimore			COUNTY Maryland			STATE		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.			ADDRESS 7922 Wise Avenue Dundalk, MD. 21222			25a. DATE REC'D. BY REGISTRAR JUN 19 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davison</i>								

30 18 11 5
12 5 5 5
~~smooth~~
Highly polished smooth
smooth surface on
surface of
three parallel lines

smooth surface on
the left side of the
smooth surface on the right side

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial/transit permit. Then please remove carbon paper page 1 and 2 should be filled with 7 day death stamp with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 0 4 1 6 3 5 1

1 DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE T.	LAST TAYLOR	2a DATE OF DEATH 06 06 84	MONTH JUNE	DAY 4	YEAR 1984	2b HOUR 6:30 A.M.		
3. SEX MALE			4 RACE WHITE	5. DATE OF BIRTH MONTH 02 DAY 06 YEAR 37			6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.			IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 6	MIN. 30
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a USUAL OCCUPATION INSPECTOR			12b KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE			
13a STATE MARYLAND			13b COUNTY ---			13c CITY OR TOWN BALTIMORE			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST JOHN			MIDDLE T.	LAST TAYLOR SR.	15. MOTHER'S MAIDEN NAME FIRST MARIE			MIDDLE	LAST WELSH			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 216-32-3412			17. INFORMANT ROSEMARY TAYLOR			ADDRESS 940 WILMINGTON AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CARDIAC TAMPOONADE (1200 cc)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) FIBRINOUS PERICARDITIS									
			DUE TO, OR AS A CONSEQUENCE OF (c) HYPOPROTHROMBINEMIA									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
MYOCARDIAL INFARCTION												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. 19 P.M.			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Michael P. Pelzar			DEGREE MS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/6/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL PELZAR			22e ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 06-09-84			23c NAME OF CEMETERY OR CREMATORIAL LOUDON PARK			23d LOCATION CITY OR TOWN BALTIMORE CITY COUNTY MARYLAND STATE			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 4107 WILKENS AVE.			25a DATE REC'D. BY REGISTRAR JUN 8 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendall			



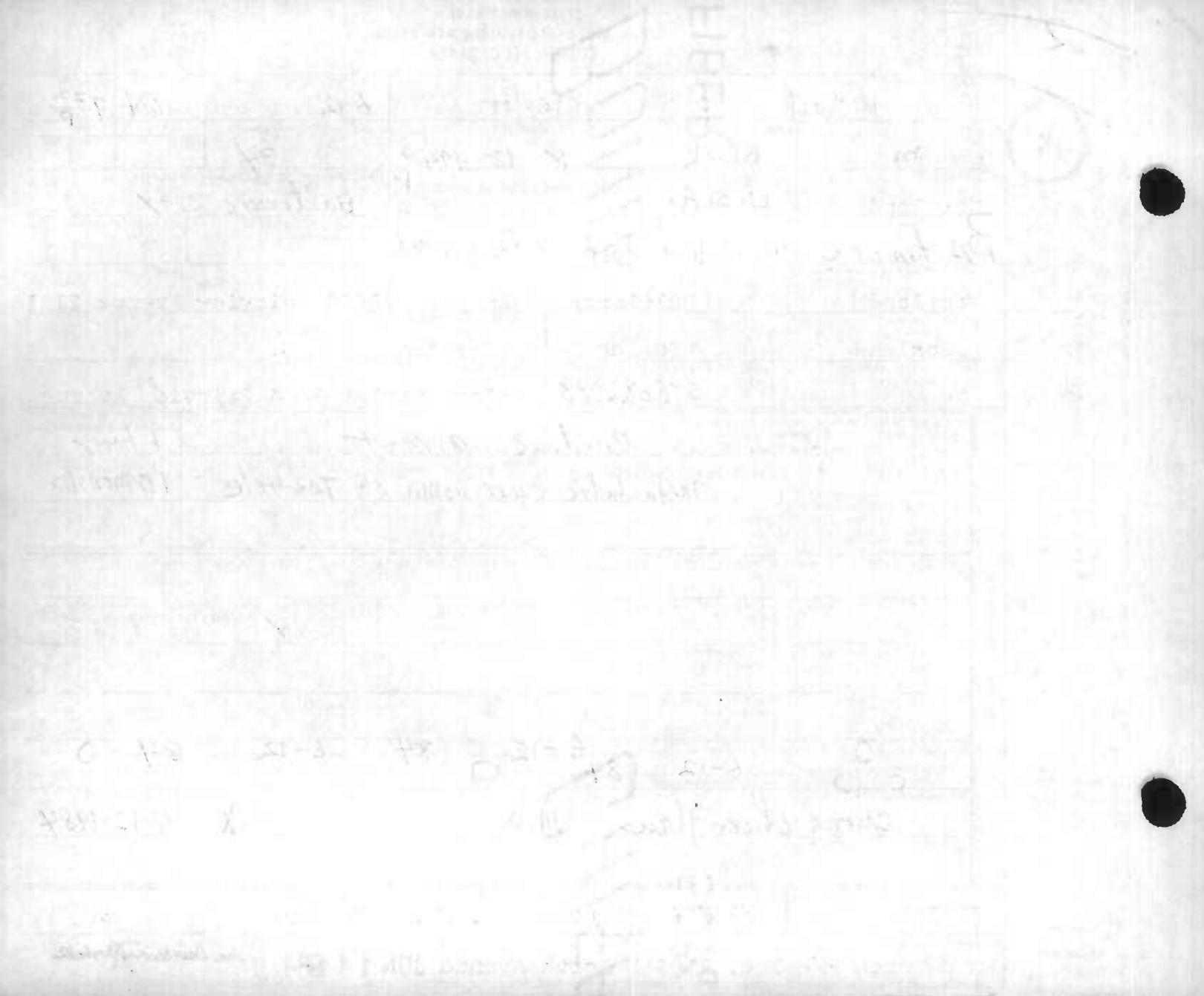
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be joined with page 2 for use with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with an "X", show any injury, or other traumatic event, the medical examiner will be called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3 4 1 6 3 5 2			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>Michael P. Taylor</i>						<i>6-12</i>			<i>6-12</i>	<i>1984</i>	<i>9 22 PM</i>				
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
<i>m</i>			<i>Black</i>		<i>8 18 1949</i>			<i>8</i>	<i>18</i>	<i>1949</i>	IF UNDER 1 YEAR				
7b. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS				
<i>Maryland</i>			<i>U.S.A.</i>		<i>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></i>			<i>Baltimore city</i>			MONTHS DAYS HOURS MIN.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
<i>Baltimore</i>			<i>Provident Hosp., Baltimore, Md.</i>									12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
<i>Maryland</i>					<i>Baltimore</i>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<i>3406 Fairview Avenue 21216</i>				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
<i>Garland</i>					<i>Taylor</i>	<i>Jessica</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.									17. INFORMANT			
<i>NO</i>			<i>578682088</i>									<i>Garland Taylor 3406 Fairview Avenue</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>															<i>1 hour</i>
1869 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) <i>Metastatic carcinoma of Testicle</i>															<i>10 months</i>
{ DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>6-12</i> , 19 <i>84</i> , to <i>6-12</i> , 19 <i>84</i> , that (1) (we) last saw the deceased alive on <i>6-12</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.															
22b. SIGNATURE <i>Chong choon Han</i>			22c. DEGREE <i>M.D.</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED <i>6-12-1984</i>						
22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE <i>6/16/84</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Arbutus Mem. Pk.</i>			23d. LOCATION CITY OR TOWN <i>Arbutus,</i>			COUNTY	STATE		
24. FUNERAL DIRECTOR <i>Wm C March F/H Inc.</i>			25a. ADDRESS <i>1101 E North Avenue</i>			25b. DATE REC'D. BY REGISTRAR <i>JUN 14 1984</i>			25b. REGISTRAR'S SIGNATURE <i>John Davidson - F/H Inc.</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if performed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												6353		
1 - FOR STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Robert</i>	MIDDLE <i>Taylor</i>	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
3. SEX		4. RACE	5. DATE OF BIRTH	JUNE 3, 1957			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTO., Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE City</i>			YRS.		MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH <i>BALTO.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>DEATON MEDICAL CENTER</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ST. JOSEPH</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>27217</i>							
13a. STATE <i>MD.</i>		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. STREET ADDRESS / ZIP CODE <i>625 W. LAFAYETTE AVE.</i>							
14. FATHER'S NAME FIRST <i>GEORGE</i>		MIDDLE <i></i>	LAST <i>TAYLOR</i>	15. MOTHER'S MAIDEN NAME FIRST <i>DAISEY</i>			MIDDLE <i></i>	LAST <i></i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-30-5416</i>		17. INFORMANT			ADDRESS <i>REBECCA DESKINS 1341 MYRTLE AVE.</i>							
18. CAUSE OF DEATH (Enter only one cause of death for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Cardiogulmonary failure</i>												APPROXIMATE PATIENT AL BETWEEN DEATH AND AUTOPSY		
DUE TO, OR AS A CONSEQUENCE OF <i>Recurrent CVAD</i>														
DUE TO, OR AS A CONSEQUENCE OF <i>Multile pressure ulcers</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>1825</i>			CITY OR TOWN <i>1984</i>	COUNTY <i>1984</i>	STATE <i>1984</i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>June 25</i> , 1984, to <i>June 25</i> , 1984, that (I) (we) last saw the deceased alive above, (I) (we) (did) (did) view the body after death.														
22b. SIGNATURE <i>Julian W. Reed</i>														
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. DATE SIGNED <i>6/26/84</i>														
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Julian W. Reed</i>		22f. ADDRESS <i>615 CHAS. ST. BALTO. MD. 21230</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE <i>6/29/84</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>KING MEM. PK.</i>			23d. LOCATION CITY OR TOWN <i>GRANTIE, Md.</i>			COUNTY	STATE			
24. FUNERAL DIRECTOR <i>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</i>		25a. ADDRESS <i></i>			25b. DATE REC'D. BY REGISTRAR <i>JUN 28 1984</i>			25c. REGISTRAR'S SIGNATURE <i>Jane Garrison-Henderson</i>						

July

Report

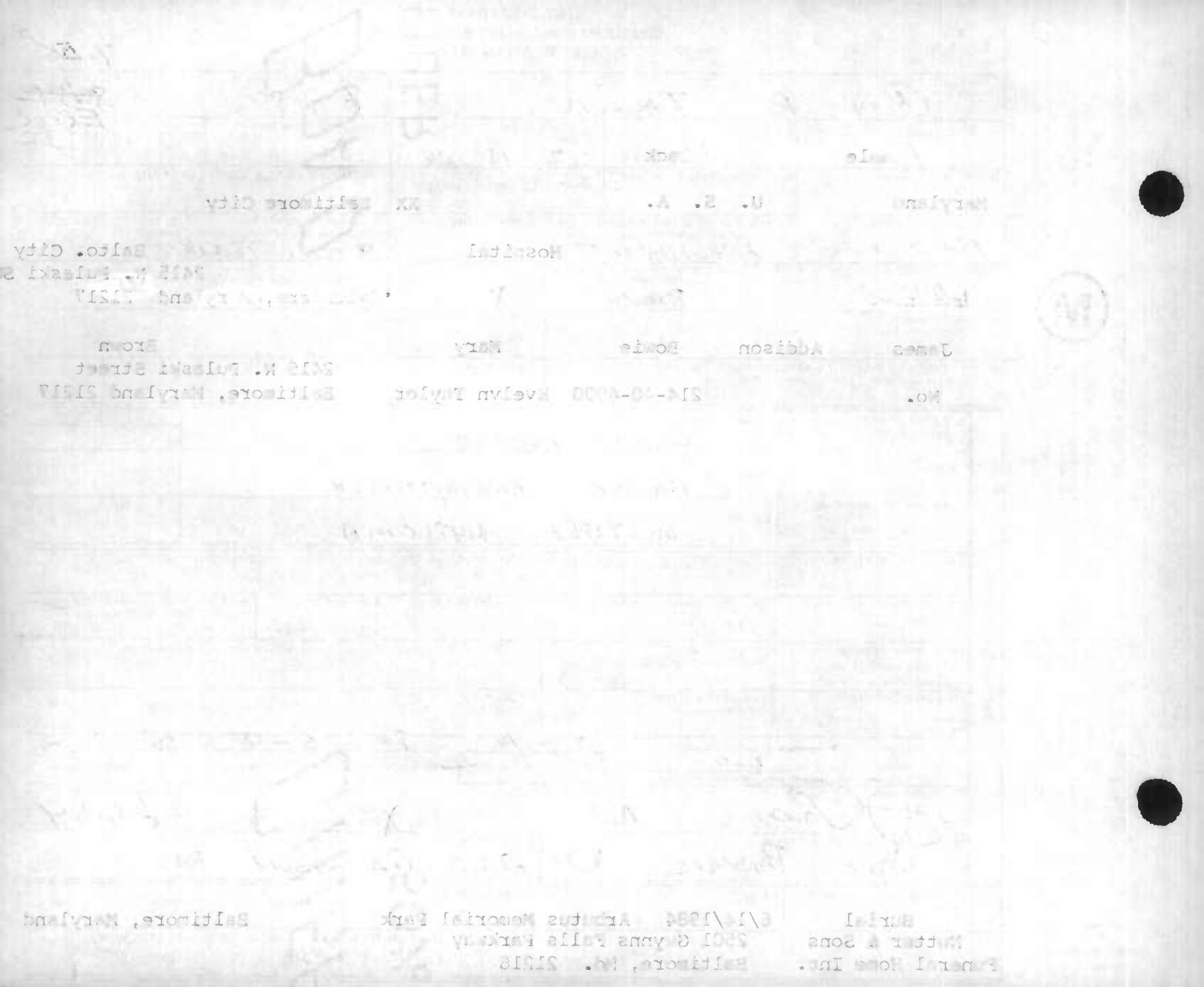
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 3 4 1 6 3 5 4 P 7:56 P													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR			26. HOUR				
Ruth R Taylor						6-9-84			8:57 A.M. ECCR				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MINUTES			
Female		Black		2 18 04			80 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U. S. A.					Baltimore City						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Balt.		PROVIDENT Hospital					SCHOOL TEACHER			Balto. City			
13a. STATE		11c. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			2415 N. Pulaski St			
Maryland		Baltimore					Baltimore, Maryland 21217						
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST			LAST			
James		Addison		Mary			Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			2415 N. Pulaski Street						
No.		214-40-4900		Evelyn Taylor			Baltimore, Maryland 21217						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 2030 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARRHYTHMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE MYELOMIA													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (the hospital) attended the deceased from 5 - 14 19 80, to 6 - 9 19 84, that (2) (we) last saw the deceased alive on 6 - 9 - 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jeff Parker		DEGREE D		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-9-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeff Parker		D		22e. ADDRESS 2300 Garrison Blvd									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/14/1984		23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Memorial Park			23d. LOCATION CITY OR TOWN Baltimore, Maryland		COUNTY		STATE		
24. FUNERAL HOME INC. NAME Nutter & Sons Funeral Home Inc.		2501 Gwynns Falls Parkway ADDRESS Baltimore, Md. 21216		25a. DATE REC'D. BY REGISTRAR JUN 12 1984			25b. REGISTRAR'S SIGNATURE Ridson Parker						



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 4 1 6 3 5 5

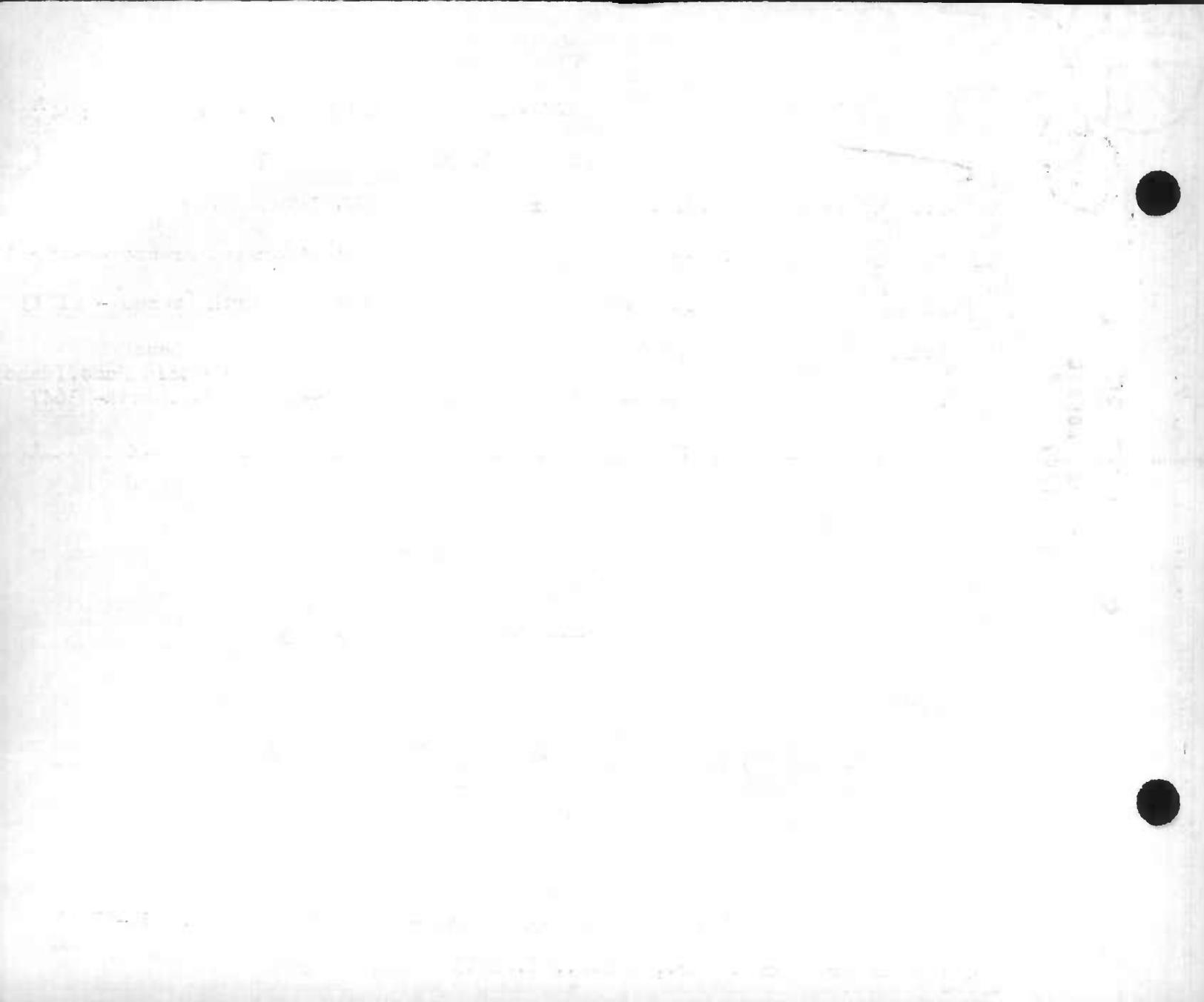
I - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST SOPHIE	MIDDLE TAYLOR	LAST	2a. DATE OF DEATH JUNE 10, 1984	MONTH JUN	DAY 10	YEAR 1984	2b. HOUR 8:04 A.M.		
1c. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 1, 1907			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ladies' Garment Presser-Retired			12b. KIND OF BUSINESS OR INDUSTRY Presser-Retired				
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1833 E. North Avenue - 21213					
14. FATHER'S NAME FIRST Frank		MIDDLE Simacek	LAST	15. MOTHER'S MAIDEN NAME FIRST Sophia			MIDDLE	LAST Lenc				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-01-7258			17. INFORMANT Cecil Earl Cockrum-435 E. 10th. North-83647			ADDRESS Mountain Home, Idaho				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrical Mechanical Dissociation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Within Minutes												
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction Within Hours (c) Coronary artery disease												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/10/84 to 6/10/84 , that (I) (we) last saw the deceased alive on 6/10/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE David H Madoff		22c. DEGREE MD PHD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) David H Madoff		22f. ADDRESS The Johns Hopkins Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 13, 1984		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery			23d. LOCATION CITY OR TOWN Baltimore City, Md.-21213					
24. FUNERAL DIRECTOR NAME Henry Sander & Sons, Inc., Balt., Md. 21213		25a. DATE REC'D. BY REGISTRAR JUN 13 1984			25b. REGISTRAR'S SIGNATURE Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed, it may be used for burial or cremation. Then please sign and return to the funeral director. Item 2 should be detached for use at the burial or cremation service.

IMPORTANT: If item 21 in marked on Item 18 shows any injury or disease, attach a separate sheet.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, *if* retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, *if* it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

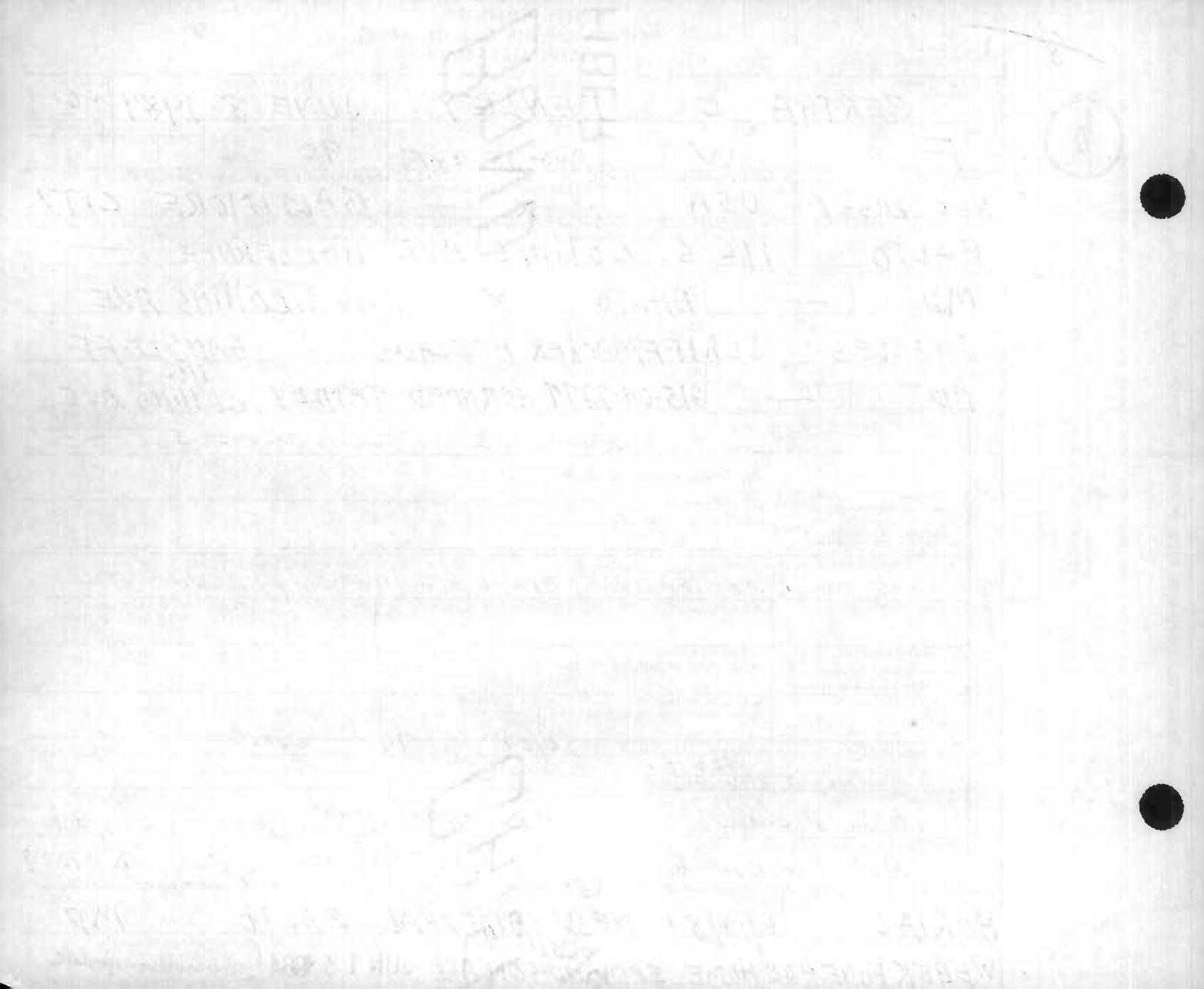
IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be called or sent to the scene.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4 1 6350

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>BERTHA C TENLEY</i>						<i>JUNE 8</i>			<i>1984</i>	<i>~6 PM M</i>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IN YEARS LAST BIRTHDAY		8. IF UNDER 1 YEAR			
<i>F</i>		<i>W</i>		<i>AUG 18 1893</i>		<i>90</i>		<i>YRS.</i>		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				11. KIND OF BUSINESS OR INDUSTRY	
<i>NEW JERSEY</i>		<i>USA</i>				<i>BALTIMORE CITY MD.</i>		<i>HOUSEWIFE</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
<i>BALTIMORE</i>		<i>116 S. COLLINS AVE</i>		<i>MD</i>		<i>—</i>		<i>BALTIMORE</i>		<i>YES</i>		<i>116 S. COLLINS AVE 21229</i>	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	ADDRESS			
<i>CHARLES</i>				<i>SCHIFFMACHER ADELADE</i>					<i>GANGLOFF</i>	<i>116 S. COLLINS AVE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<i>NO</i>		<i>315-09-2277</i>		<i>BERNARD TENLEY</i>									
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		BREAST CANCER - LEFT									
<i>1749</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)											
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive Heart Failure, Atrial Fibrillation, Malnutrition</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>5/23/84</i> , 19 <i>76</i> , to <i>76</i> , 19 <i>76</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>5/23/84</i> , 19 <i>76</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <i>Albin O. Kuhn Jr</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN		22e. DATE SIGNED <i>6/11/84</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Albin O. Kuhn Jr</i>		22e. ADDRESS <i>1001 PINE HEIGHTS AVE, BALT., MD. 21229</i>											
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>6/13/84</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>NEW CATHEDRAL</i>		23d. LOCATION CITY OR TOWN <i>BALTIMORE</i>		COUNTY		STATE <i>MD</i>			
24. FUNERAL DIRECTOR NAME <i>WEBER FUNERAL HOME</i>		ADDRESS <i>5311 EPPMONDSON AVE</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 13 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from page 3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 -
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 04 | 6357

1. DECEASED NAME (TYPE OR PRINT)			FIRST GLORIA	MIDDLE ROSETTA	LAST TERRELL	2a. DATE OF DEATH MONTH 12 - 7 - 34	DAY 34	YEAR 49	2b. HOUR 6 7 84	8 46 A M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 12 - 7 - 34		6. AGE (IN YEARS LAST BIRTHDAY) YRS 49		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS HOURS 8	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		MD.	
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4108 Rokeby Road, 21229					
14. FATHER'S NAME FIRST William		MIDDLE E.	LAST Mc Cullough	15. MOTHER'S MAIDEN NAME FIRST Rosetta		16. ADDRESS 338 B Melvin Avenue		17. INFORMANT Michael Terrell		18. LAST Austin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-0876		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: Pulmonary emphysema, masked 4920 IMMEDIATE CAUSE (a)		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF							
{		(c)		DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/15 1984 to 6/7 1984 , to 6/7 1984 , that (I/we) last saw the deceased alive on 6/7 1984 , and that in (my) <input checked="" type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I/we) did <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE Lillian E. Hickens, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.E. Hickens, M.D.		22e. ADDRESS St. Agnes Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/1984		23c. NAME OF CEMETERY OR OTHER ADDRESS Garrison Forest Veterans Cemetery		23d. LOCATION CITY OR TOWN Baltimore, Maryland					
24. FUNERAL DIRECTOR Nutter & Sons Funeral Home Inc.		2501 Gwynns Falls Pkwy. ADDRESS Baltimore, Md. 21216		25a. DATE REC'D. BY REGISTRAR JUN 12 1984		25b. REGISTERED BY John [Signature]					

NOT

Ward

Recruit

MC Cityhood

Ward

300 S Main Ave

Baltimore, Maryland 21202

No.

Baltimore, Maryland

AT&T BELL SYSTEM
2001 Charles Street Baltimore

MD 21218
Baltimore, MD 21218

Interne & Son
Business Inc.
Baltimore, MD 21218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified of it.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16358			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST							
THELMA E. TERRY													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR IF UNDER 24 HRS HOURS MIN.		
FEMALE		BLACK		9 25 18				65 YRS.			2:30 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD.		
VIRGINIA		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE		ST. AGNES HOSPITAL											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
MARYLAND				BALTIMORE							3711 HARLEM AVENUE		
14. FATHER'S NAME		FIRST MIDDLE		LAST				15. MOTHER'S MAIDEN NAME					
HARRISON				HOWARD				ANNIE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS					
NO								ANTHONY TERRY, SR. 106 DINER PL.			21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Atherosclerosis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED AT WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) this hospital attended the deceased from <u>saw the deceased alive on about 5/28</u> 19 <u>84</u> , to <u>19 87</u> present, 19 <u> </u> , that (1) (we) last above (1)(we) (did) did not view the body after death.												22b. DATE SIGNED 01/31/84	
22c. SIGNATURE <u>C. Carter MD</u>		22d. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carter</u>		22f. ADDRESS				22g. NAME OF CEMETERY OR Crematory <u>Bon Secours Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. LOCATION CITY, TOWN				23d. DATE REC'D. BY REGISTRAR		23e. REGISTRATION NUMBER			
Burial		4/16/1844		Maryland Hospital Laurel, Maryland				JUN 18 1984					
24. FUNERAL DIRECTOR NAME <u>Bailey Funeral Home</u>		ADDRESS <u>1348 W. Calhoun</u>				25. REGISTRATION NUMBER							
BP													

4700 800

11/11
11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												16359			
												REG. NO.			
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR
			WILLIAM CLERMONT THAW						6 22 84						408 A M
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			WHITE			MONTH DAY YEAR			91 YRS			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY			
VIRGINIA			U.S.A.												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE			ST. AGNES HOSPITAL						PRINTER						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			---			BALTIMORE						3327 WINTERBOURNE ROAD, 21216			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
RICHARD L. THAW						ALICE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						ADDRESS			
NO			219-10-0345			MRS. PEGGY B. PURCELL			1143 McHENRY DRIVE			GLEN BURNIE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AIDS															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of hip															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
			Fracture of hip			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 01/21/84, to 01/22/84, that (I) (we) lost saw the deceased alive on 01/22/84, 19_____, and that in my knowledge depth of my information, the causes stated above, (I) (we) (did) (did not) view the body after death.						DEGREE			RECORDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			21g. DATE SIGNED			
22b. SIGNATURE Michael G. Macon, M.D.												01/22/84			
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS			ST. AGNES HOSPITAL, 900 S. CATON AVENUE									
MICHAEL G. MACON, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OF BALTIMORE CITY		COUNTY MARYLAND STATE	
CREMATION			6/26/84			LOUDON PARK									
24. FUNERAL DIRECTOR NAME			ADDRESS			21229			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE JUN 27 1984 John Davidson Pendell			
HUBBARD FUNERAL HOME, INC.			4107 WILKENS AVE.												

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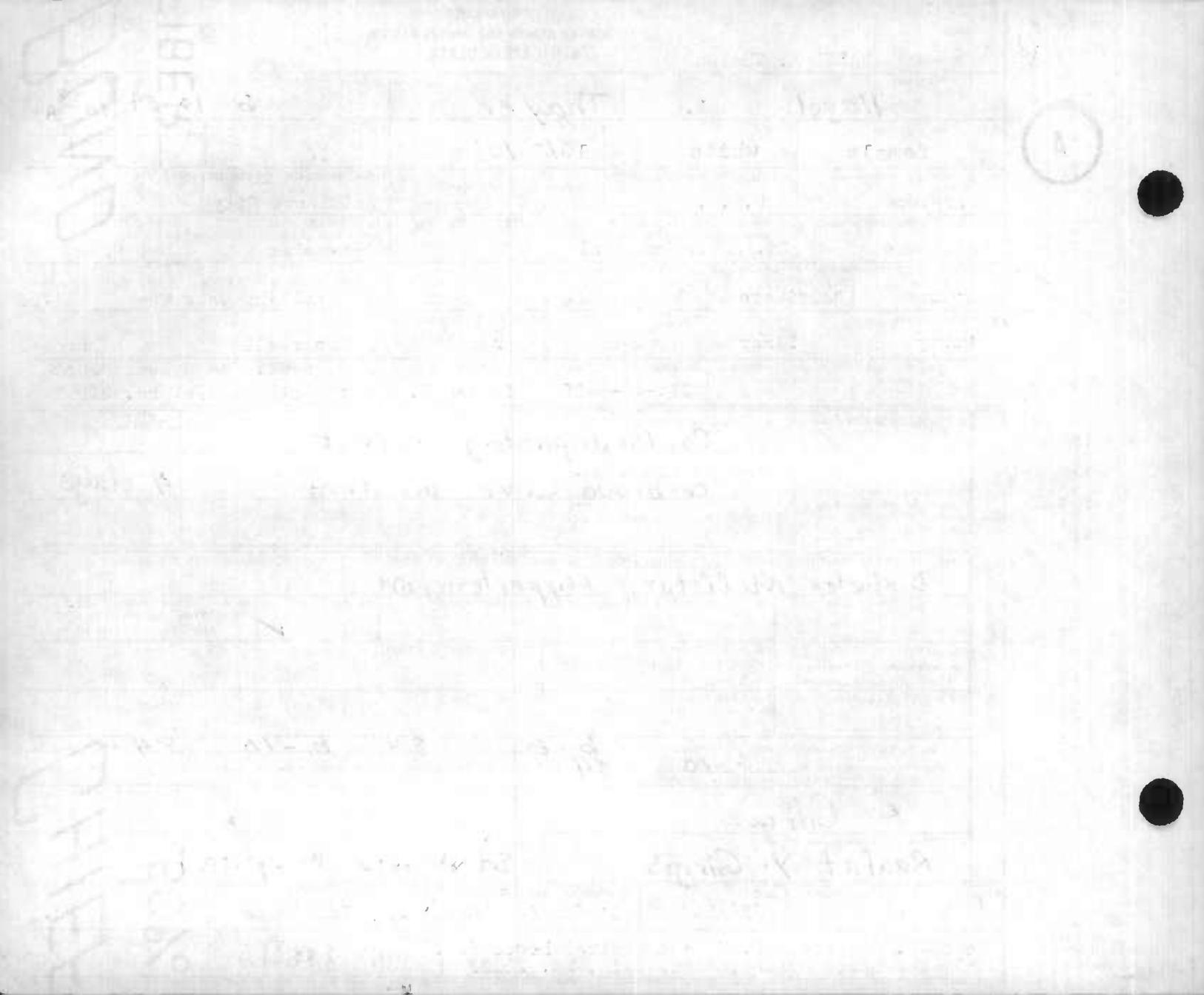
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove the carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO. 4 16360															
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Hazel E. Thayer</i>			E.		<i>Thayer</i>			6 10 84					10 38 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		10/28/05			78			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Baltimore City MD.					
Maryland		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore		St. Agnes Hospital		Homemaker			Own Home								
13a. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland		Baltimore		Catonsville			9F Rambling Oaks Way 21228								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Harry	Elmer	Tucker	Ada Marshall			214-46-9428			William S. Thayer Lutherville, Md. 21093				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (c)													
		4 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).		<i>Diabetes Mellitus, Hypertension</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>6-6</u> , 19 <u>84</u> , to <u>6-10</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6-10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>R. Girgis</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Raafat Y. Girgis</i>			22e. ADDRESS <i>St. Agnes Hospital</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/14/84			23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore COUNTY Md.						
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228						25a. DATE REC'D. BY REGISTRAR JUN 12 1984			25b. REGISTRAR'S SIGNATURE <i>J. M. Witzke</i>						

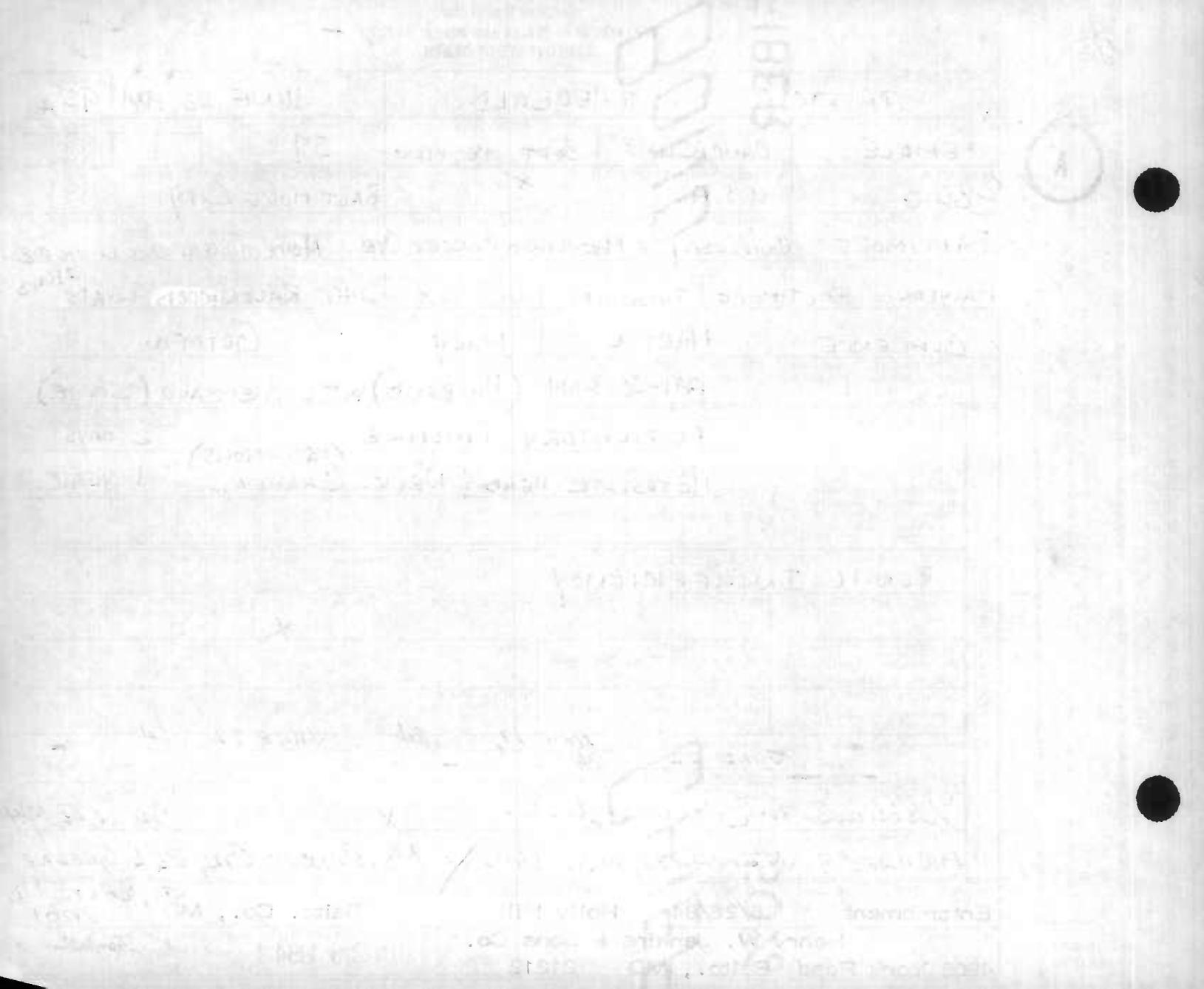


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST				JUNE 22, 1984 905 A.M.						
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
FEMALE			CAUCASIAN		SEPT 18, 1926			57 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
BALTIMORE OHIO			U.S.A.					BALTIMORE CITY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE			UNIVERSITY OF MARYLAND CANCER CTR.		Homeemaker Own Home								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MARYLAND			BALTIMORE		TIMONIUM						2400 RAVENVIEW ROAD 21093		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
CLARENCE MARTIN			MARY GRIFFIN										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			291-20-3444			(HUSBAND) W.H.L. THEOBALD (SAME)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC HEAD & NECK CANCER (SQUAMOUS) BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													2 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)													1 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RENAL INSUFFICIENCY													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from May 17, 1984, to June 22, 1984, that (I) () lost saw the deceased alive on JUNE 22, 1984, and that in (my) () opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.													
22b. SIGNATURE MICHAEL B. STEWART, M.D.													22c. DATE SIGNED June 22, 1984
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS MICHAEL B. STEWART, M.D. UNIV. OF MD. CANCER CTR. 725 S. GREENE										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE 6/26/84		23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill			23d. LOCATION CITY OR TOWN Balto. Co., MD COUNTY BALTIMORE 21261					
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212			25a. DATE REC'D. BY REGISTRAR JUN 25 1984			25b. REGISTRAR'S SIGNATURE ...R. Anderson-Randall							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 16362				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			6-12 6-12-84 2:31 P.M.				
AMELIA M. THOMAS																
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
FEMALE			WHITE			11 15 07			76 YRS.							
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD.				
M.D.			U.S.A.			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE			SOUTH BALTIMORE GEN HOSPITAL									RETIRED.			Housewife	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			MD 21230	
MD			-----			BALTIMORE						1505 WEBSTER ST BALTIMORE				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST			BLUMENSHTEIN	
HENRY			-----			YOUNGMAN			CATHERINE			-----			-----	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(YES, IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21236 Mrs. Gloria L. Diegel, 8930 Carlisle Ave. Balto.	
No						212-09-3110			Mrs. Gloria L. Diegel, 8930 Carlisle Ave. Balto.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																
DUE TO, OR AS A CONSEQUENCE OF (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/12 1984 to 6/12 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE M. M. MODRA														DEGREE		
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														22c. DATE SIGNED 6/12/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 1828 Rustling Oaks Drive Millersville													
M. M. MODRA																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 16, 1984 Meadowridge Mem. Park			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN Elkridge Howard Co. Md.			MD 21188				
24. FUNERAL DIRECTOR McCarthy Funeral Home, 130 E. Fort Ave. Balto. Md.			21230			25a. DATE REC'D. BY REGISTRAR JUN 15 1984			25b. REGISTRAR'S SIGNATURE John McCarthy							

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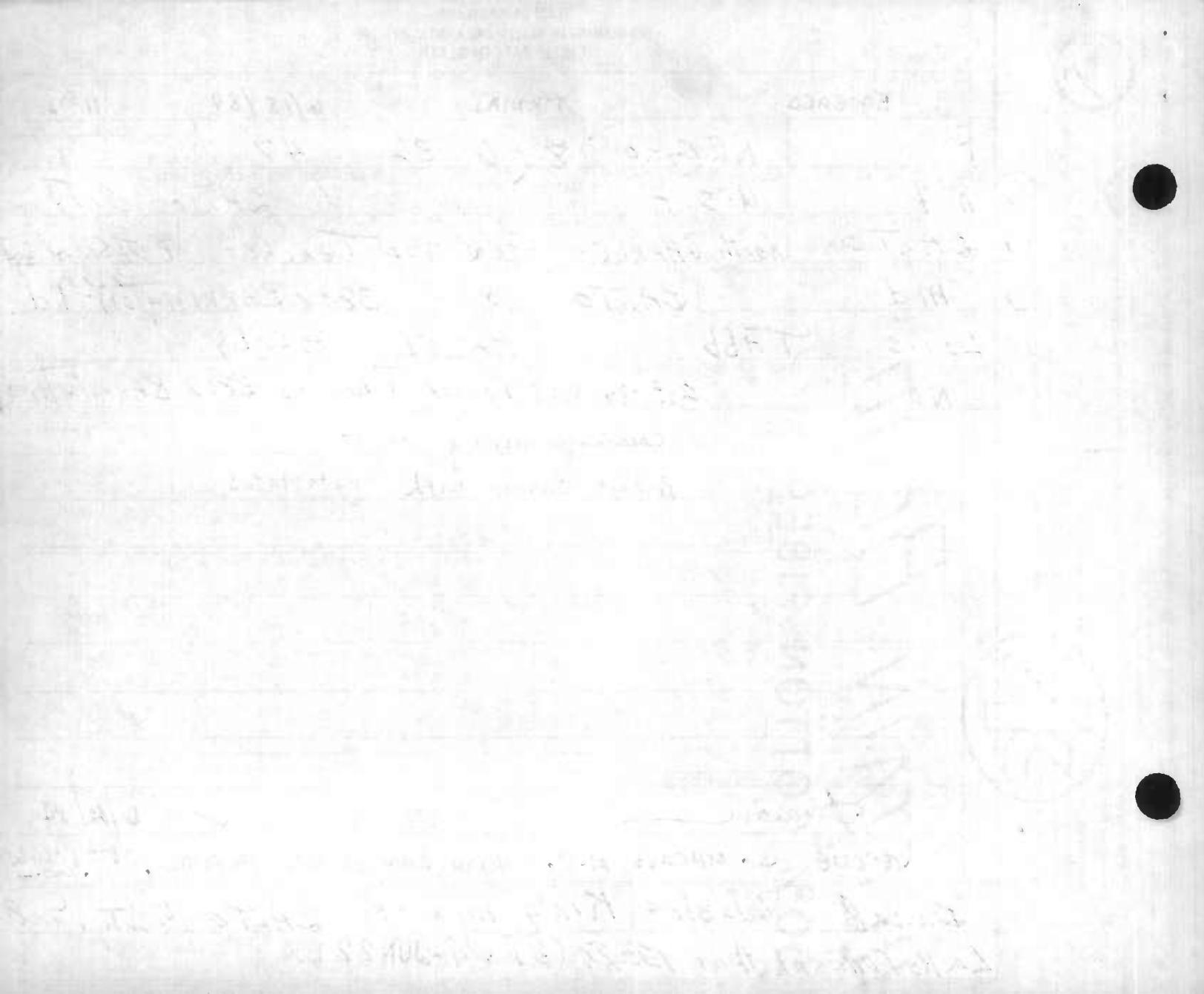
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16363							
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 6/18/84							2b. HOUR 11:55 A.M.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			THOMAS			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.					
3. SEX F.			4. RACE NEGRO			8 6 36			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North CHARLES GEN. Hosp			12a. USUAL OCCUPATION Teacher			12b. KIND OF BUSINESS OR INDUSTRY BALTIMORE SCHOOLS								
13a. STATE Md		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3808 BARRINGTON Rd.								
14. FATHER'S NAME FIRST Louis TABB LAST			15. MOTHER'S MAIDEN NAME FIRST HAZEL MIDDLE Ashby LAST														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-34-4265			17. INFORMANT IRVIN Thomas			ADDRESS 3808 BARRINGTON Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BREAST CANCER WITH METASTASES																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE JEROME S. MARAVE										22c. DATE SIGNED 6/21/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEROME S. MARAVE, M.D.			22e. ADDRESS NORTH CHARLES GEN. HOSPITAL, 38TH ST. & Charles														
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 6/23/84			23c. NAME OF CEMETERY OR CREMATORIAL KING MEM PK			23d. LOCATION CITY, COUNTY BALTIMORE County, MD								
24. FUNERAL DIRECTOR LARKS FUNERAL HOME 1304 N. GILDED			25. DATE RECEIVED BY REGISTRAR JUN 22 1984							25b. REGISTRAR'S SIGNATURE							



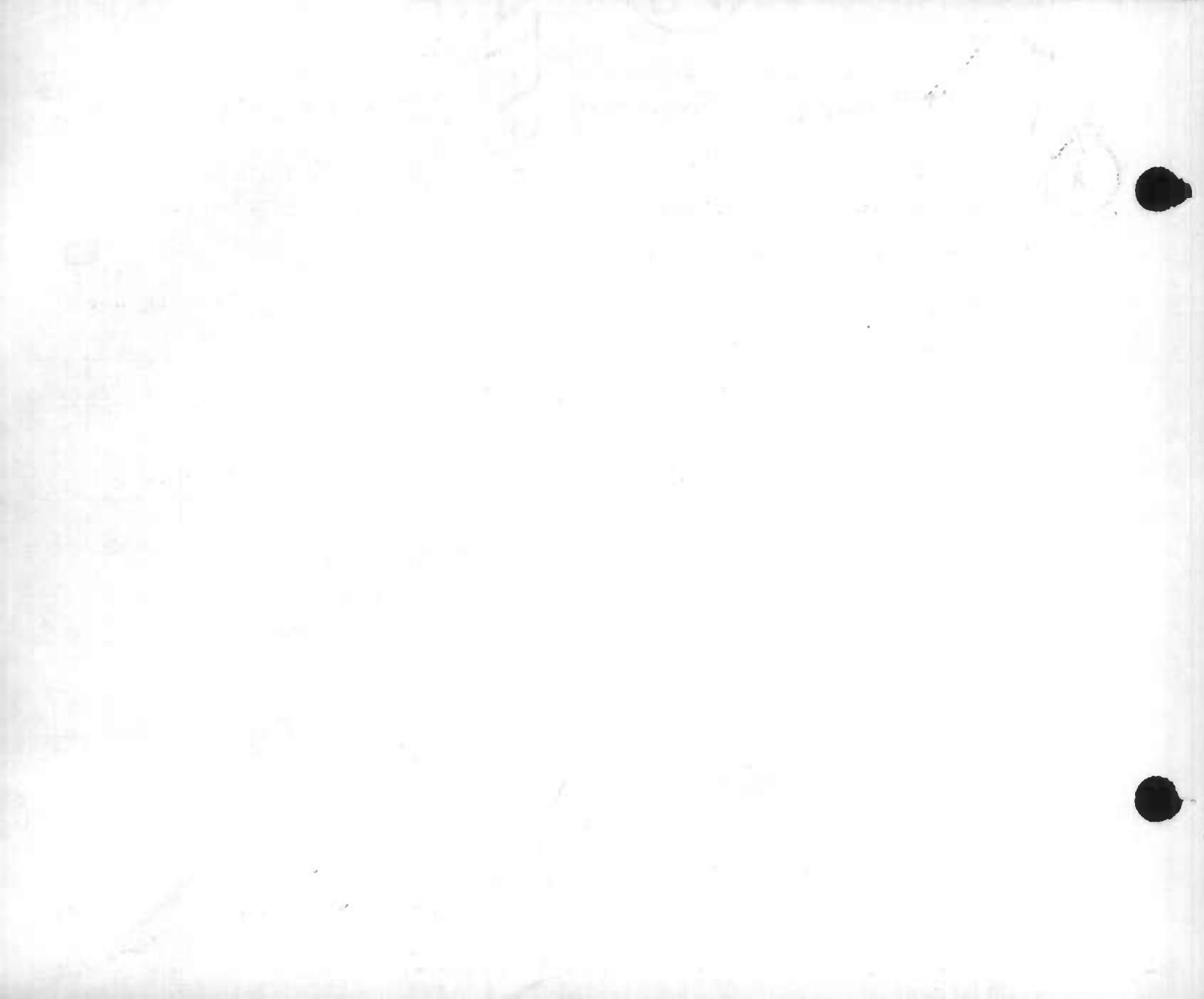
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety, it should be detached for use as the burial/transit permit. Then please remove carbon copy (Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the certificate is filed.

MEDICAL CERTIFICATION

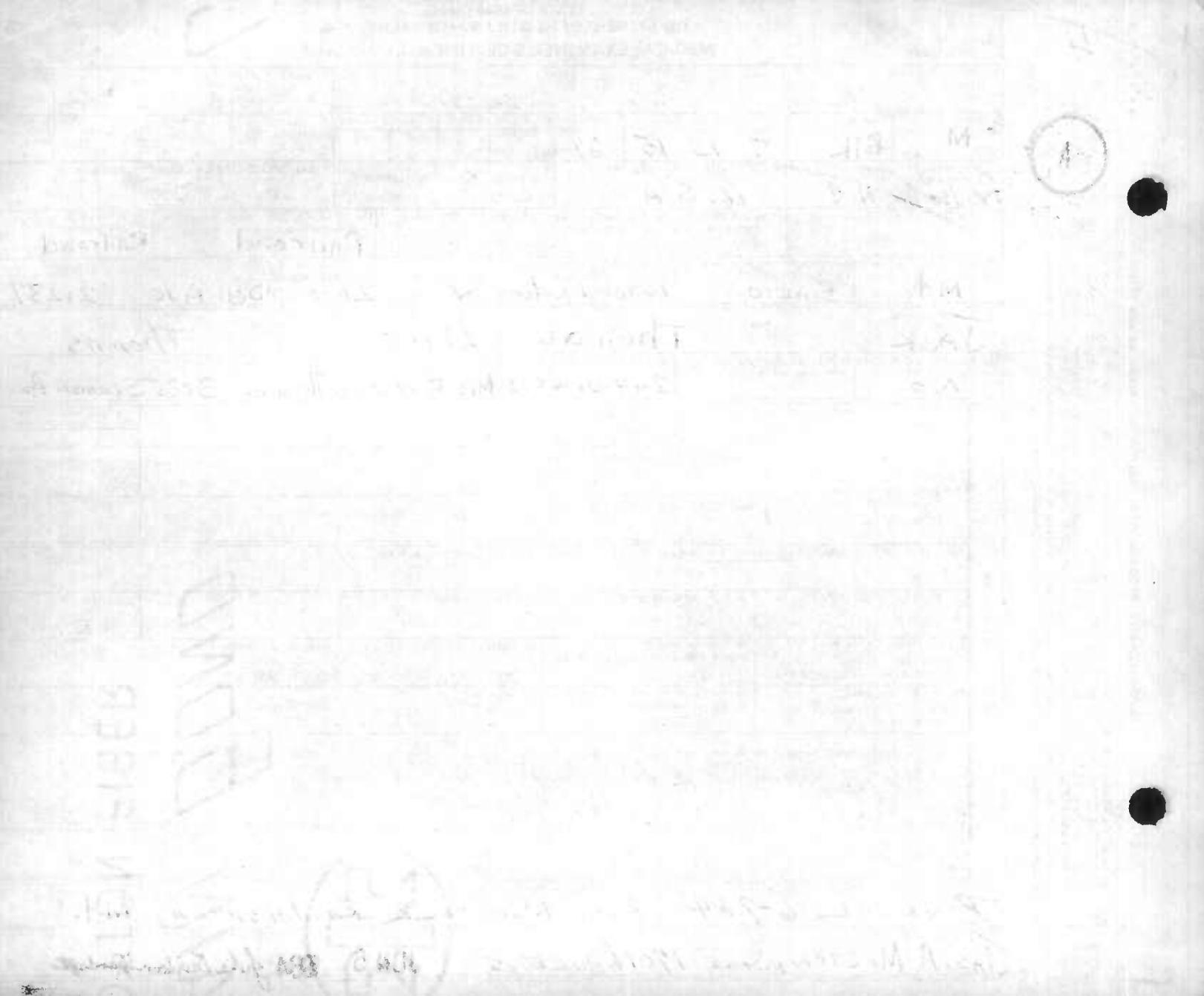
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 4 1 6 3 6 4				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR				
James Thomas						6-28-84				11 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Black		9 27 15			68 YRS.			MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY, MD.				
S. Carolina		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		BON SECOURS HOSPITAL												
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE				21216		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN				2825 W. Lafayette Avenue						
14. FATHER'S NAME FIRST Warren		MIDDLE Thomas		15. MOTHER'S MAIDEN NAME FIRST Elizabeth			MIDDLE Rose							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 251-03-0445		17. INFORMANT Janie L. Thomas			ADDRESS 2825 W. Lafayette Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous Cell Carcinoma of Lung</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>6/25</i> , 19 <i>84</i> , to <i>6/28</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>6/28</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Roger Bebraway</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/28/84</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Roger Bebraway</i>		22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (<input type="checkbox"/> BURIAL)		23b. DATE 7/3/84		23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Memorial Pk.			23d. LOCATION CITY/TOWN Arbutus, COUNTY Md. STATE							
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue			25a. DATE REC'D. BY REGISTRAR JUL 2 1984			25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson-Pendell</i>						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 OR YOUR COPY OF THE CERTIFICATE AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16365		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH EST. MATED	XX	MONTH	DAY	YEAR	2b. HOUR			
James E. Thomas						6-2	1984	M						
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE [IN YEARS LAST BIRTHDAY]	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR			
M	B/K	5 15 15	69 yrs.			6-2	1984				8:09 a.m.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Reidsville N.C.		U.S.A.					Baltimore City,							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		2000 O'Dell Ave. -rear court yard			Railroad		Railroad							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Md.		BALTO		Hollind Ridge		NO		2000 O'Dell Ave. 21237						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS						
Jack				Thomas		Lillie		Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9571		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		244-01-6070		Mrs. Earlean Thomas		Multiple Injuries								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		(a)		DUE TO, OR AS A CONSEQUENCE OF										
		(b)		DUE TO, OR AS A CONSEQUENCE OF										
		(c)		DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			8:00xx 6-2 1984			subject jumped from building								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
			Home			2000 O'Dell Ave., Baltimore, Maryland								
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER												DATE SIGNED 6-2-84		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION OR TOWN CITY OR TOWN COUNTY STATE					
BYRISL 6-9-84						King Mem Park			Randallstown, Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
JAS. A. MORTON & SONS			1901 Laurens			JUN 6 1984 Julia Davidson Pendleton								



5FT
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16366

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
LLOYD			M.	THOMAS	Sr.	6-5-84	19		M		
3. SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	black	2 14 12	72 yrs.			6-5-84	19		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.							Baltimore City		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		Lutheran Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS				
Maryland				Baltimore			615 Linnard Street 21229				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
William			Thomas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
Yes		217-05-3630			Lloyd M. Thomas, Jr.		615 Linnard St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Margarita Korell</i> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			DATE SIGNED 6-6-84						
Margarita A. Korell, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/11/84		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery Crownsville,		23d. LOCATION CITY COUNTY STATE					
BP											
DHMH - 17 (VR A15 ME (5)) 20M 4/82		24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 7 1984		25b. REGISTRAR'S SIGNATURE <i>Sue Davidson Rendall</i>			
		Wm C March F/H Inc.		1101 E North Avenue							

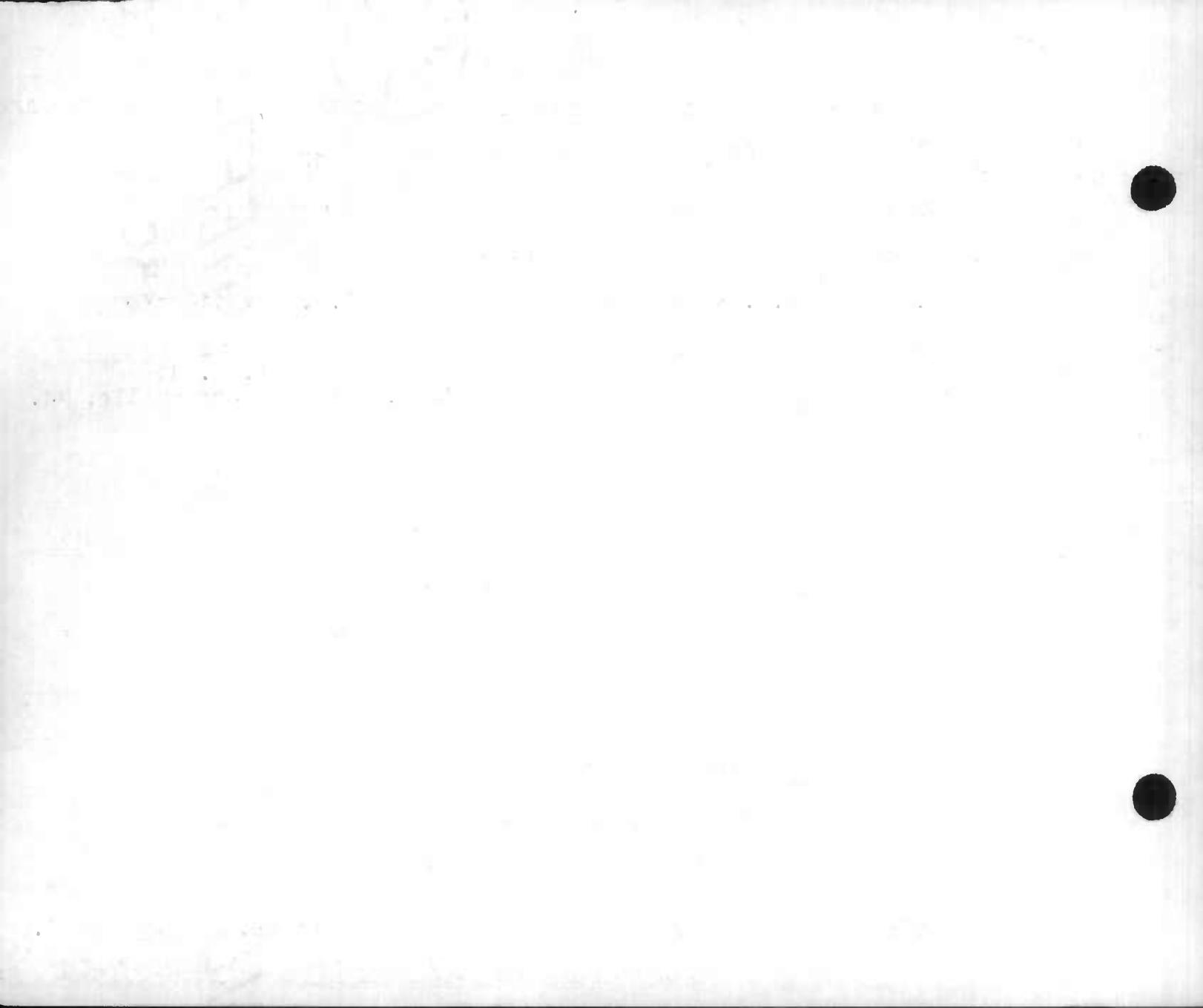
100 500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Part 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked and Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16361				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			JUNE 18, 1984							12:09 AM	
NICOLE R THOMAS														
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH 3 DAY 12 YEAR 72			6. AGE (IN YEARS LAST BIRTHDAY) 12 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Q.A. ✓ Centreville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE P.O. Box 116 21617					
14. FATHER'S NAME FIRST Allen MIDDLE Holmes LAST			15. MOTHER'S MAIDEN NAME FIRST Roberta MIDDLE Thomas LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Roberta T. Price			ADDRESS P. O. 116 Gransonville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDI-RESPIRATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0				
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE ACUTE MON-LYMPHOCYTIC LEUKEMIA WITH										2 WEEKS				
DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY LEUKEMIC INFILTRATES										4 WEEKS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. hemorrhagic cystitis, gram negative sepsis														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1984, to JUNE 18, 1984, that (I) <input type="checkbox"/> lost saw the deceased alive on 6/18 1984, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> view the body after death.														
22b. SIGNATURE Sharon Kay Peek, MD										22c. DATE SIGNED 6/18/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sharon KAY PECK, MD			22e. ADDRESS Johns Hopkins Hosp.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/21/84			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn			23d. LOCATION CITY OR TOWN Easton, Tal			COUNTY STATE Md.		
24. FUNERAL DIRECTOR NAME ERIC L. DASHIELL R.O. Box 606, Preston										25a. DATE REC'D. BY REGISTRAR JUN 27 1984				
ADDRESS ERIC L. DASHIELL R.O. Box 606, Preston										25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use on the burial-travel permit. Then please return certificates pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

4 1 6 3 6 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Charles William Thompson</i>						6	3	84	9:20 A M		
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Caucasian		MONTH 4	DAY 29	YEAR 25	59 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Balto., MD.		USA		Baltimore City					MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		St. Bells H.		Security Guard.			Westinghouse				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		21224			7834 Eastside Rd. Baltimore MD.		
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Solomon DALE Thompson						LEONA ELIZABETH Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
YES		WWII 1943-46 218-14-2798		PATRICIA THOMPSON			21 Treeway Ct. #11				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cardio-Respiratory arrest</i>											
1539 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Auto pulmonary/thromboembolism</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cancer</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5/28/84</i> to <i>6/3/84</i> , that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Conrad H. J. DeWeese, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>5/28/84</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Angela DeWeese</i>		22e. ADDRESS <i>3001 S. Hanover St. Baltimore MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial 6/6/1984</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Mem. Pk.</i>		23d. LOCATION CITY OR TOWN <i>Glen Burnie, A.A.C.</i>					
24. FUNERAL DIRECTOR NAME <i>McCullum Funeral Homes</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 5 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Ma. Davis</i>							

Hannibal - 2 good fish net traps were broken
the day after arrival 300' from shore

Two salmon traps

No traps



2

2

2

2

2

2

2

2

2

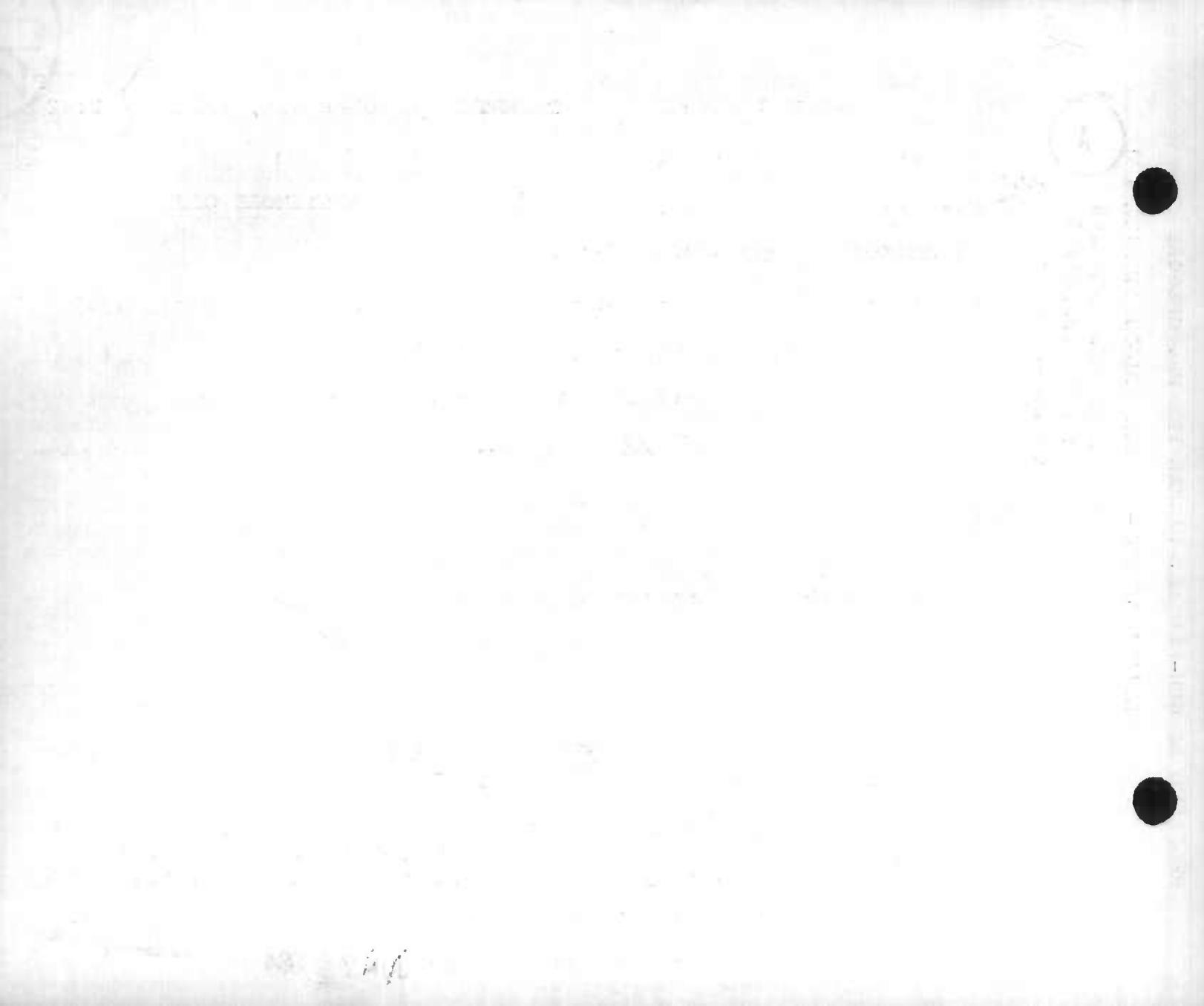
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 3 6 9

REG. NO.

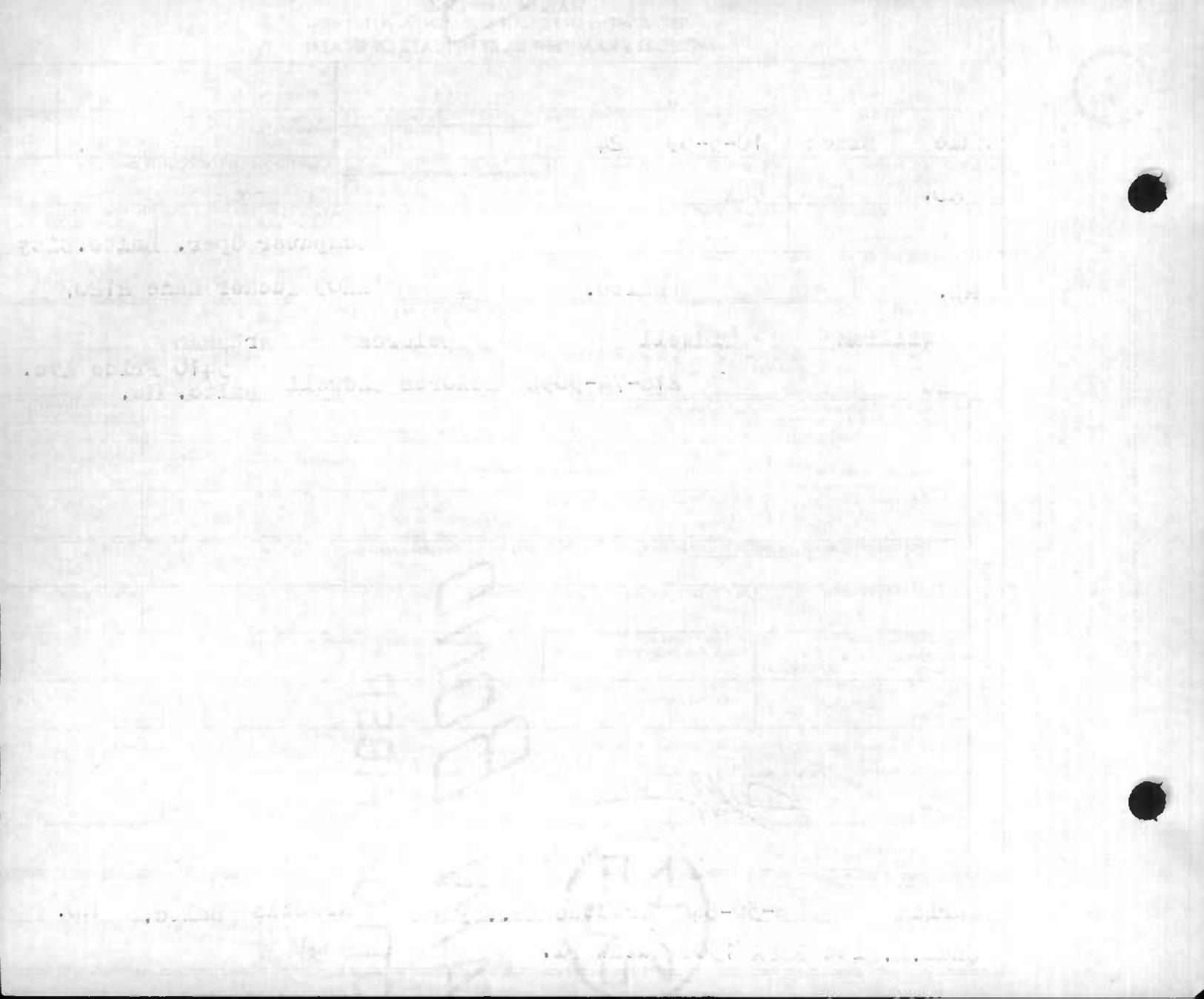
1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RUBEN (WALDEN) (RUBIN)			MIDDLE WALTER	LAST THORNTON Jr.	2a. DATE OF DEATH JUNE 5TH, 1984	MONTH YEAR	2b. HOUR 2:42 P.M.
3c. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 9	DAY 30	YEAR 42	6. AGE (IN YEARS LAST BIRTHDAY) 41	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN. 00
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1225 Greenmount Ave., 21202	
FATHER'S NAME FIRST Ruben	MIDDLE W.	LAST Thornton, Sr.	15. MOTHER'S MAIDEN NAME FIRST Priscilla		MIDDLE	LAST White	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-40-9012		17. INFORMANT Priscilla White	ADDRESS 1225 Greenmount Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 3030 IMMEDIATE CAUSE (a) Sudden Death APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown							
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b. Alcoholism Seizures							
19a. DATE OF OPERATION:		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:			19a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	19b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART II) 5 June 1984			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) this hospital attended the deceased from 5 June 1984 , to 19 , that (2) <input type="checkbox"/> was last seen alive on 5 June 1984 , and that in my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> have <input type="checkbox"/> not viewed the body after death.							
22b. SIGNATURE Jim Walker DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED 6 Jun 84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jim Walker		22e. ADDRESS THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTO. MD. 21205					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/11/84	23c. NAME OF CEMETERY OR CREMATORIAL Eastview Mem. Pk.		23d. LOCATION CITY OR TOWN Baltimore, Md.	STATE	
24. FUNERAL DIRECTOR Wm C March F/H Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR JUN 7 1984		25b. REGISTRAR'S SIGNATURE June Sanders Pendleton	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5, FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 370					
1- STATE REGISTRAR			1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI. DEATH MATED			2b. HOUR MONTH DAY YEAR					
(TYPE OR PRINT)			Keith G Tidwell						<input checked="" type="checkbox"/>			6 24 1984					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR MONTH DAY YEAR		
Male		Black		10-5-59		24 yrs.						6 24 1984			8:56 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MD.			USA										Baltimore City				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			Provident Hospital						Computer Oper. Balto. City								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			ADDRESS					
MD.					Balto.				2209 Tucker Lane 21207			5410 Price Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						16. ADDRESS			Balto. Md.					
William Tidwell			Delores														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.						17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			218-74-5096						Delores Tidwell								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertrophic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?								
									<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 																	
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St. Balto., MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6-30-84			23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem. Park			23d. LOCATION CITY OR TOWN Arbutus			COUNTY Balto.		STATE MD.			
Burial																	
24. FUNERAL DIRECTOR NAME Chas.A.Rice FSPA			ADDRESS 1300 Eutaw Pl.						25a. DATE REC'D. BY REGISTRAR JUN 29 1984			75b. REC'D. BY		75c. REC'D. BY			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do my best.

relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 7 1			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ruth	MIDDLE Anna	LAST Tieperman			2a. DATE OF DEATH MONTH June			DAY 15, 1984	YEAR		2b. HOUR 10:15 AM	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH April			DAY 21	YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City						
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1506 Pentridge Rd. Apt. 127			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21239 1506 Pentridge Rd. Apt. 127						
14. FATHER'S NAME FIRST John			MIDDLE Henry			LAST Ziegler			15. MOTHER'S MAIDEN NAME FIRST Clara			MIDDLE Grimes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-01-4228			17. INFORMANT Harry P. Robbins			10000 PRES. LYONS MILL RD. Owings Mills Md. 21117			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DOUE TO, OR AS A CONSEQUENCE OF (b) <i>CHF ASCVD</i> DOUE TO, OR AS A CONSEQUENCE OF (c) <i>CVA</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia <i>CVA</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (1) this hospital attended the deceased from 6 19 81 to 6 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on above, (1) (we) did not view the body after death.															
22b. SIGNATURE <i>Maren M. Ross</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 6/16/84						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 18, 1984			23c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cem.			23d. LOCATION CITY OR TOWN Pikesville			COUNTY Baltimore	STATE Md.		
24. FUNERAL DIRECTOR NAME <i>R. Gary Bechtling</i>			25a. DATE REC'D. BY REGISTRAR JUN 19 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendell</i>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE KEPT FOR 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

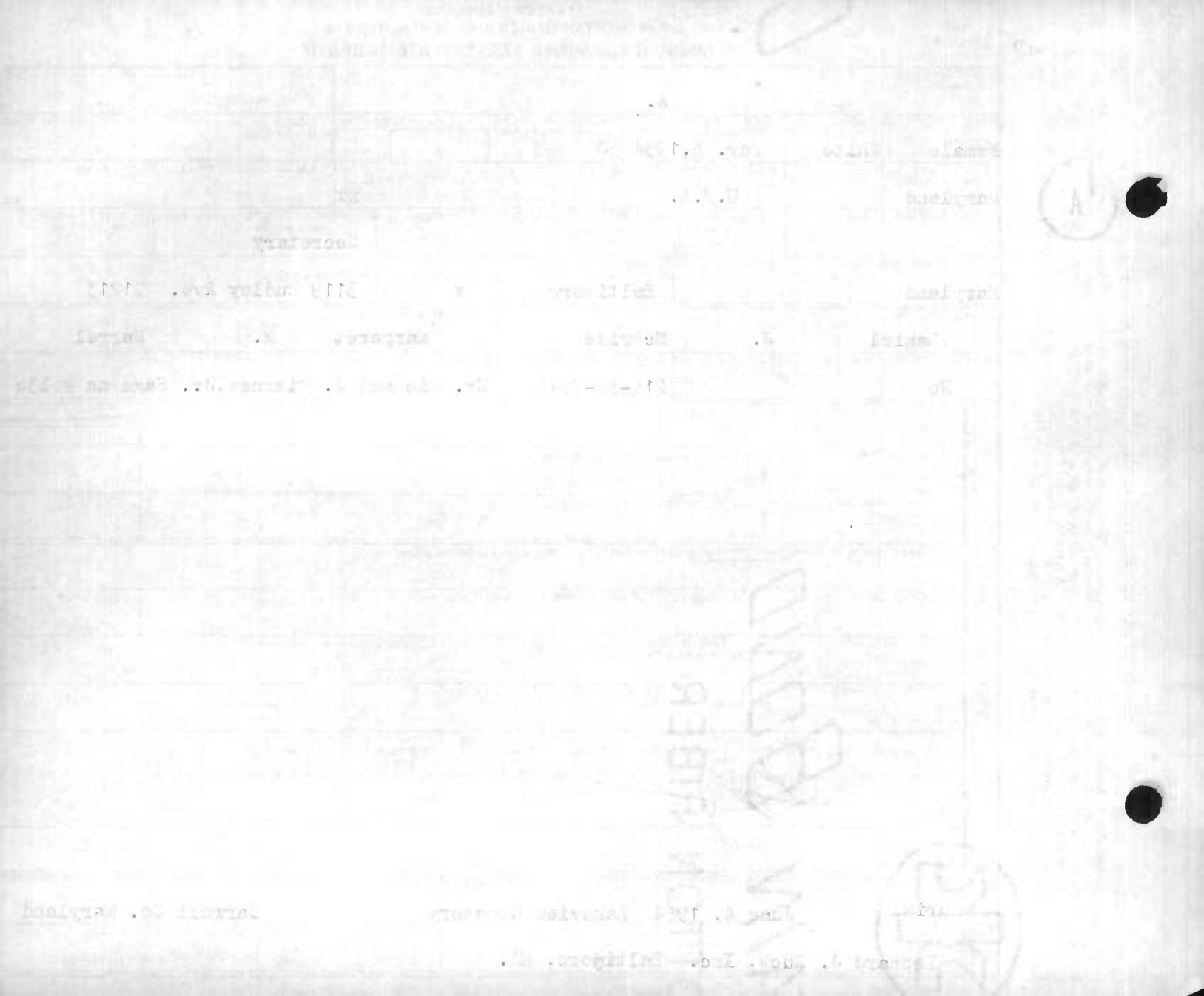
MEDICAL CERTIFICATION

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16372

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR		
Margraet			A.	Tierney		6/1/84	19					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Female	White	Mar. 6, 1934	50 yrs.			6/1/84	19			7:48 AM		
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7f. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.					Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		3500 Blk. Belair Road			Secretary							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Baltimore	3119 Dudley Ave. 21213									
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Daniel		J.	McBride	Margaret		M.	Farrel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		216-30-7946		Mr. Michael J. Tierney, Jr.		Same as # 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6/1/84 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found shot								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) car		21f. LOCATION STREET 3596 Belair Road, Balto. City, Md.		CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Gregory R. Kauffman, M.D.</u>											TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)											DATE SIGNED 6/1/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Burial		June 4, 1984		Lakeview Cemetery		Carroll Co. Maryland		JUN 4 1984			<u>Julia L. Johnson</u>	
24. FUNERAL DIRECTOR NAME		ADDRESS										
Leonard J. Ruck, Inc.		Baltimore, Md.										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be buried or cremated. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
6 4 1 6 3 7 3											
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MILDRED VIRGINIA TILLMAN							JUNE 29, 1984				5:25A _M
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10/21/1908			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL, INC.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON			12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 213 N. MILTON AVENUE 21224		
14. FATHER'S NAME FIRST HENRY		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST LOUISA						LAST BATZ	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215.28.5805A		17. INFORMANT WILLIAM C. GARTRELL			ADDRESS 213 N. MILTON AVENUE BALTIMORE, MD. 21224			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) SUPERIMPOSED ASPIRATION PNEUMONIA											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
STATUS POST MAXXKETOMEXXOR MASTECTOMY FOR KK BREAST CANCER											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from JUNE 12, 1984 to JUNE 29, 1984 , that (I) we lost saw the deceased alive on JUNE 29, 1984 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.											
22b. SIGNATURE <i>John Mannisi</i> MD		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 6/29/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MANNISI, MD.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD 21231									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6/30/1984		23c. NAME OF CEMETERY OR CREMATORIAL GREEN MOUNT CREMATORIAL			23d. LOCATION CITY OR TOWN BALTIMORE,			COUNTY STATE MARYLAND	
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222		ADDRESS			25a. DATE REC'D. BY REGISTRAR JUL 3 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

(A)



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, CALL THE MEDICAL EXAMINER DIRECTLY OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT IN FULL. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18-22a 9/10/84 mtb #595 STATE OF MARYLAND
FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16374
REG. NO.

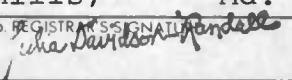
1. DECEASED NAME (TYPE OR PRINT)		FIRST Eva	MIDDLE Tobin	LAST	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/>	MONTH 6	DAY 8	YEAR 1984	2b. HOUR M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <input checked="" type="checkbox"/>	MONTH 6	DAY 8	YEAR 1984	2d. HOUR 8:51 p.m.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS 2205 BROOKCREST WAY #21208						
14. FATHER'S NAME FIRST Noah		MIDDLE Tobis	15. MOTHER'S MAIDEN NAME FIRST Ethel								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 158-14-3108		17. INFORMANT MRS. ESTELLE ESKOW 111 HAMLET HILL RD., APT. 1004 #21210							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8880 IMMEDIATE CAUSE (a) Cranio Cerebral Trauma Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? HEAD ONLY <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:25 P.M. 6/8/1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell to ground (unknown circumstances)							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET Colby Rd. nr. Reisterstown Rd. CITY OR TOWN COUNTY STATE Balto. Co.							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Actual Signature <i>Thomas D. Smith</i> Thomas D. Smith, M.D. Deputy Chief, MEDICAL EXAMINER										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
EXAMINER'S NAME (TYPE OR PRINT)		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6-10-84	23c. NAME OF CEMETERY OR CREMATORIAL BETH ISAAC-ADATH ISRAEL		23d. LOCATION CITY OR TOWN BALTIMORE	23e. COUNTY MD	23f. STATE MD
24. FUNERAL DIRECTOR NAME 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JUN 14 1984				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					
BP 946											
DHMH - 17 (VR A15 ME (5)) 20M 4/B2											

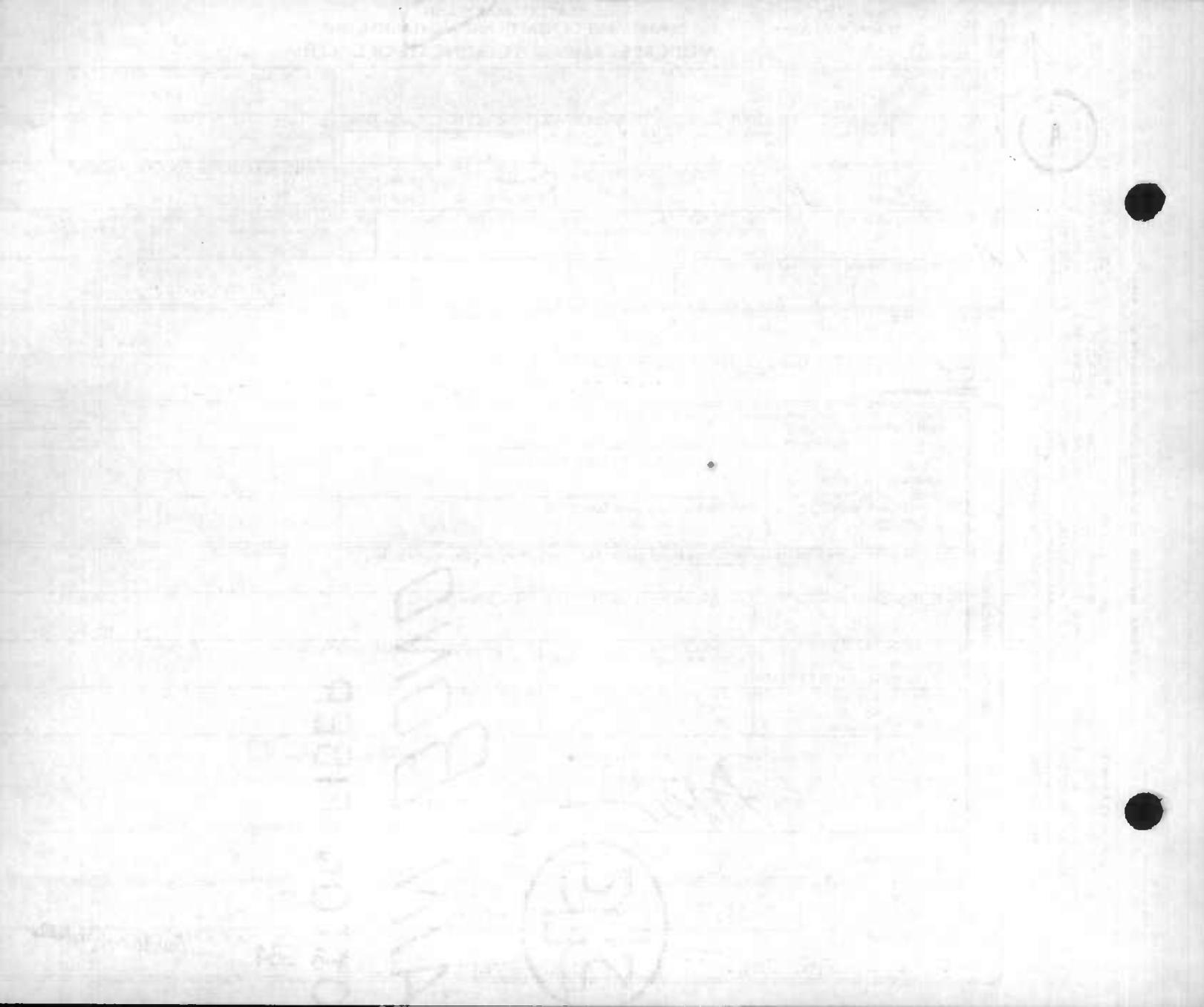
92.0-111.828



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PAGE 3, WITH A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16375
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH DAY YEAR	2b. HOUR	
William G.			Todd Jr.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6/14/84 19			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH DAY YEAR	2d. HOUR	
Male	black	9 2 51				<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	6/14/84 19			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH				MD	
Maryland		U.S.A.			<input type="checkbox"/>	<input checked="" type="checkbox"/>	Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Provident Hospital								21216		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1711 Moreland Avenue				
14. FATHER'S NAME William		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Laura		FIRST	MIDDLE	LAST	Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> UNKNOWN		16b. SOCIAL SECURITY NO. 216 52-4375		17. INFORMANT		ADDRESS Laura Todd 1711 Moreland Avenue						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Intravenous Narcotism Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE 												
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
DATE SIGNED 6/14/84												
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St., Balto., Md. 21201												
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/19/84		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA				23d. LOCATION CITY OR TOWN Owings Mills,		COUNTY	STATE Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR JUN 15 1984				25b. REGISTRAR'S SIGNATURE 				
20M 4/82												
DHMH - 17 (VR A15 ME (5))												

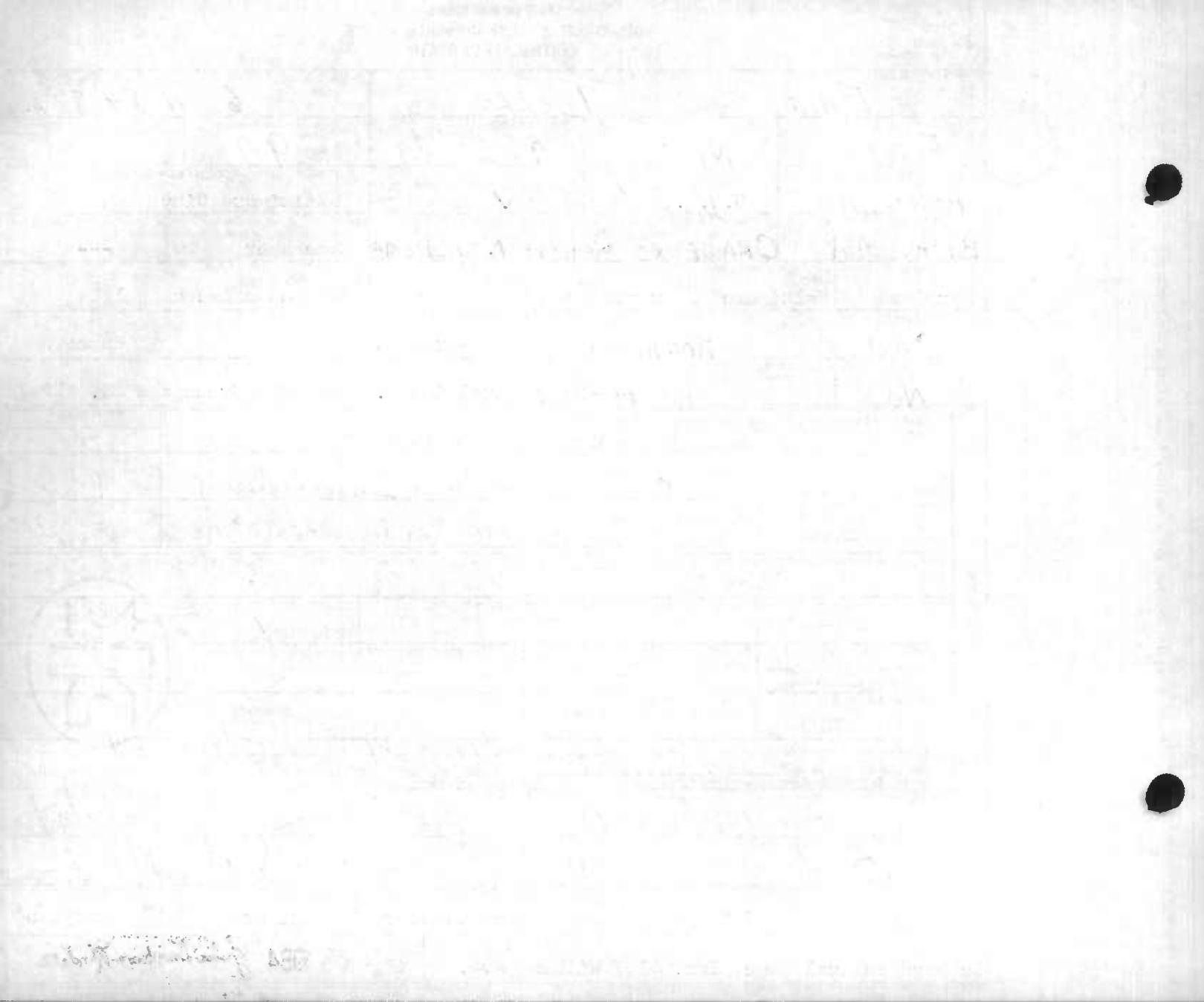


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Page 2 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3 4 1 6 3 7 6					
I. DECEASED NAME (TYPE OR PRINT)			FIRST EMMA	MIDDLE TOELLE	LAST			2a. DATE OF DEATH 6 11 84	MONTH 8 ¹⁵	DAY A.M.	YEAR 1984	2b. HOUR 8 ¹⁵			
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH 9 DAY 25 YEAR 93			6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.			IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0	
7. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			10a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		10b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
10a. STATE Maryland			10b. COUNTY Baltimore			10c. CITY OR TOWN Arbutus			10d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			10e. STREET ADDRESS 900 Leeds Avenue 21229		12b. KIND OF BUSINESS OR INDUSTRY ---	
14. FATHER'S NAME FIRST Carl			MIDDLE Knoblock			15. MOTHER'S MAIDEN NAME Caroline									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO 218-14-8283			17. INFORMANT Geraldine E. Read 1924 Greengage Rd. 21207									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4110 CARDIAC ARREST															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arterial Insufficiency												Lhr			
{ DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease 15 yrs															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/16/84 to 6/11/84, that (I) (we) last saw the deceased alive on 6/10/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 6/11/84			
22b. SIGNATURE E.O. HUNT Jr MD			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.O. HUNT Jr MD			22e. ADDRESS Crawford Retreat Nsg. Home												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/14/84			23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore			23e. COUNTY Maryland		23f. STATE Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.			ADDRESS 21229 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR JUN 13 1984			25b. REGISTRAR'S SIGNATURE Julie Anderson Rendell						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon copies. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 3 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

16311

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
STANLEY JAMES TOMASZEWSKI						JUNE 22, 1984				3:31P M						
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
Male		White		8 16 10			73									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
NEW YORK		U.S.A.					Baltimore CITY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
BALTIMORE		3426 CARDENAS AVE		MANAGER			RETAIL									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
MARYLAND				BALTIMORE						3426 CARDENAS AVE. 21213						
14. FATHER'S NAME (STANISLAUS) STANLEY		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MARY			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
							214-03-9912			WIFE 483-1478 JEANETT TOMASZEWSKI SAME AS #13			KOLESIOW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO				cardiorespiratory arrest						4 minutes						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) reflected adenocarcinoma of the lung						~ 3 yrs							
			DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (we) attended the deceased from SEPT 19 83 to JUNE 22 19 84, that (I) (we) last saw the deceased alive on JUNE 18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE Gary Gordon		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 6/23/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY Gordon		22e. ADDRESS JONNS Hopkins Hosp														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 6/23/84		23c. NAME OF CEMETERY OR CREMATORIAL BALTO., MD.			23d. LOCATION CITY OR TOWN		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME ANATOMY BOARD		ADDRESS BALTO., MD.		25a. DATE REC'D. BY REGISTRAR JUN 28 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendle									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CLARENCE J. TOOLE CERTIFICATE OF DEATH										8 4	6 3 1 8		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CLARENCE J. TOOLE					TOOLE		6 22 84					10:15P	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		Cauc.		MONTH	DAY	YEAR	71			MONTHS	DAYS	HOURS	MIN.
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE City MD.			
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore		South Baltimore Gen. Hosp.		Foreman			Newspaper						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS / ZIP CODE 4401 Ritchie Hwy. 21225				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
John				Toole		Minnie					Grey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(NO)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 212-03-0385			17. INFORMANT Betty M. Toole (same as 13e)			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DISSEMINATED INTRAVASCULAR COAGULATION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC SMALL CELL CA.</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 4</u> , 19 <u>84</u> , to <u>JUNE 22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>JUNE 22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>6/22/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HERBERT J VARBE</u>			22e. ADDRESS <u>3001 S. HANOVER ST.; BALTO., MD.</u>			22f. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 6/26/84			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem.			23d. LOCATION CITY/TOWNSHIP Baltimore			COUNTY	MD.
24. FUNERAL DIRECTOR Balto., Md. 21225 George J. Gonce F.H. 4001 Ritchie Hwy.						25a. DATE REC'D. BY REGISTRAR JUN 26 1984			25b. REGISTRAR'S SIGNATURE <u>Linda S. Randall</u>				
NAME <u>George J. Gonce F.H.</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please remove carbon papers. Pages 1 and 2 need to be filled within 72 hours.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 need to be filled within 72 hours.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please remove carbon papers. Pages 1 and 2 need to be filled within 72 hours.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please remove carbon papers. Pages 1 and 2 need to be filled within 72 hours.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

BP 15

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 3 7 9

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			Ivy		Toronto	June 14, 1984				12:00 N.			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		Caucasian	August 10, 1917			66	YRS						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				10b. KIND OF BUSINESS OR INDUSTRY		
Washington D.C.		U.S.A.			Baltimore City		Restaurant Manager				Moulin Rouge		
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. STREET ADDRESS / ZIP CODE				12b. ADDRESS	
Baltimore		Maryland General Hospital						3321 Courtleigh Drive 21207				Toronto 21207	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				13f. ADDRESS	
Maryland		Baltimore		Baltimore		NO						3321 Courtleigh Drive Baltimore, Maryland	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
George			Thomas	Edna			Himilright						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		577-22-1170		Mr. Jerry		Toronto 21207							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 5850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Gastrointestinal bleeding and Sepsis</u> Due to, or as a consequence of (c) <u>Chronic Renal Failure</u> Due to, or as a consequence of													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> , 19 <u>84</u> , to <u>6/14</u> , 19 <u>84</u> , that we lost saw the deceased alive on <u>6/14</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <input type="checkbox"/> view the body after death.													
22b. SIGNATURE <u>Gary Merritts MD</u>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED			
22e. ADDRESS Gary Merritts, M.D.		c/o Maryland General Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		6-18-84		Lake View Mem. Park		Eldersburg		Carroll		Maryland			
24. FUNERAL DIRECTOR NAME <u>Loring Byers Funeral Directors, Inc.</u> ADDRESS <u>8728 Liberty Road Randallstown, Maryland 21138</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Wilson-Burdell</u>									

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of the same institution

and all

you demand

will be given you in full and without deduction of any kind.

and if you will give me a copy of your letter I will forward it to the appropriate authority.

and if you will give me a copy of your letter I will forward it to the appropriate authority.

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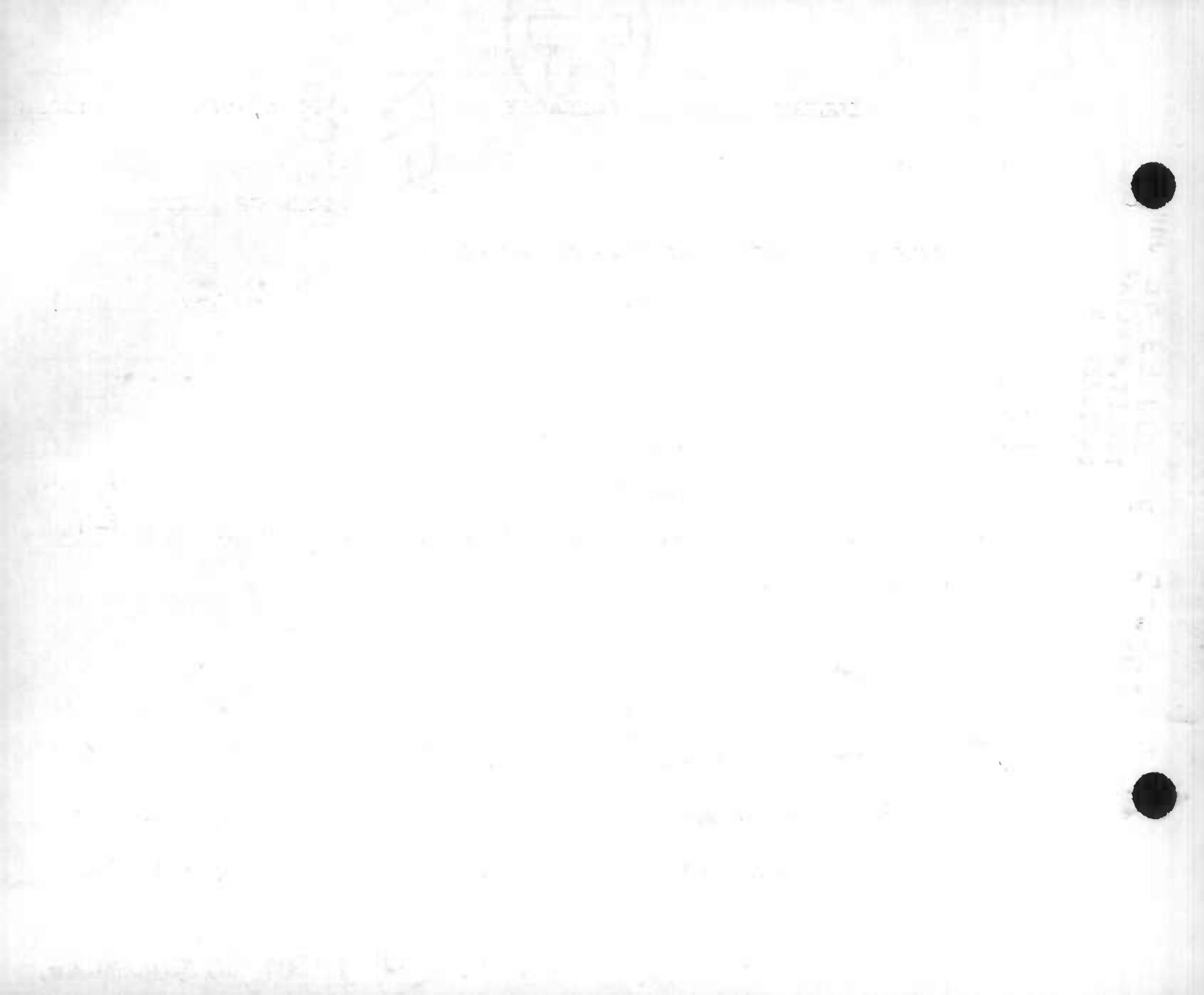
TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it should be detached from the burial permit. Then please remove this paper from the death record with the State Dept. of Health and Mental Hygiene after burial, cremation, or removal.

IMPORTANT: If Item 21 is checked, if there is any injury, or other traumatic event, no medical certification is required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	4	6	3	8	0			
												REG. NO.								
1 - FOR STATE REGISTRAR																				
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
WILLIAM					TRACEY						JUNE 6, 1984						9:50PM			
3. SEX		4. RACE			5. DATE OF BIRTH			MONTH			DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White			4 23 27			57			YRS.			MONTHS		DAYS	HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
BALTIMORE		THE JOHNS HOPKINS HOSPITAL						BALTIMORE CITY			MD.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 109 S. Broadway 21231			12b. KIND OF BUSINESS OR INDUSTRY											
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Unkn.															ca. 6 months					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
IMMEDIATE CAUSE (a) RESPIRATORY ARREST 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
(b) RUL ATELECTASIS												20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
{ DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC SMALL CELL CARCINOMA OF LUNG												20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). No heavy tobacco use																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE							
22a. I certify that (I) this hospital attended the deceased from OCTOBER 19 82 , to JUNE 6, 19 84 , that (I) (we) last saw the deceased alive on JUNE 6, 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED June 6, 1984								
22b. SIGNATURE Thomas Adams Corson M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Adams Corson, M.D.			22e. ADDRESS The Johns Hopkins Hospital, Baltimore, Maryland 21205																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 6/9/84			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN			COUNTY	STATE							
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 19 1984			25b. REGISTRAR'S SIGNATURE Julie Townsend Pandrea											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 3 AND 1 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

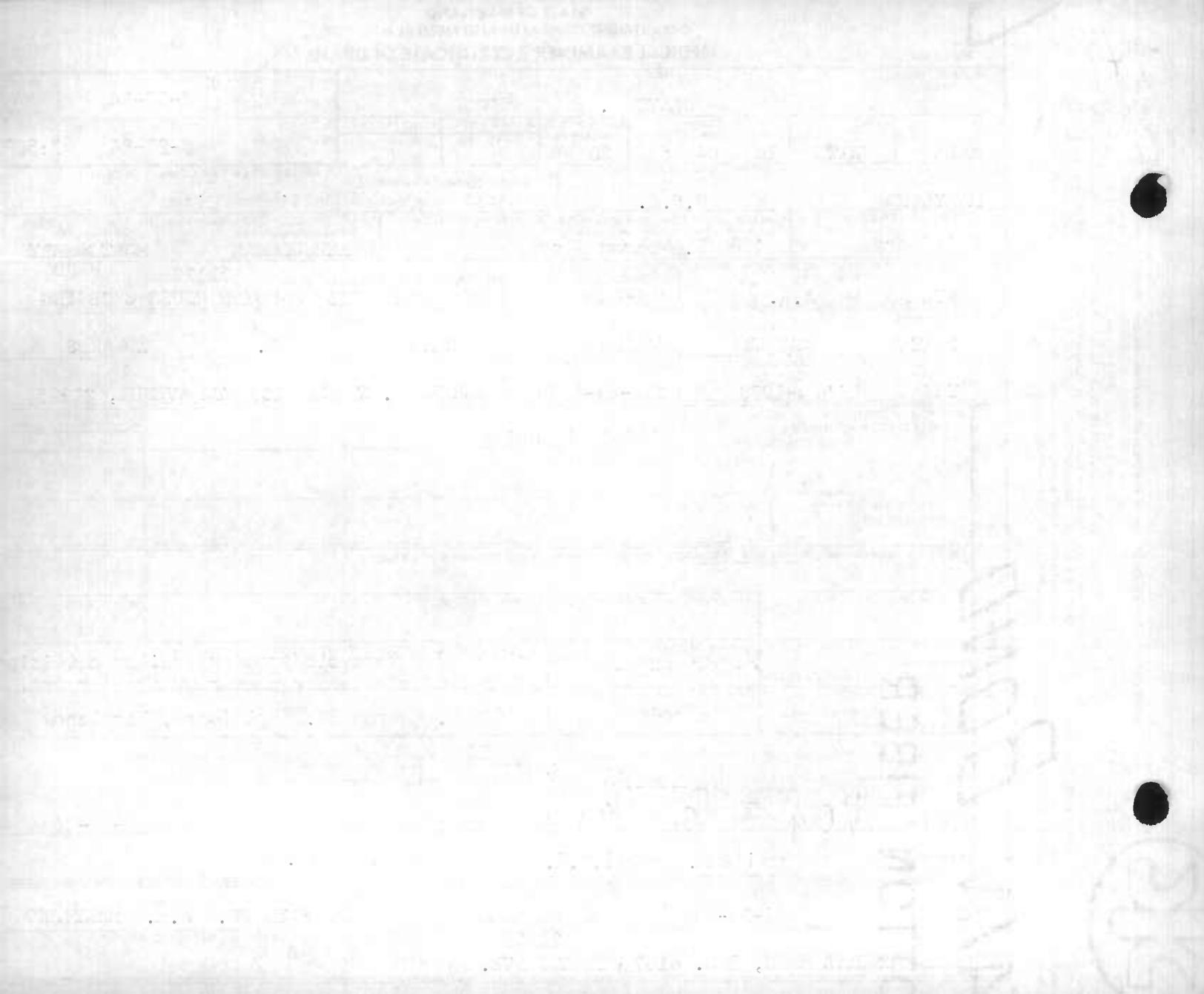
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 3 8 1	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED				MONTH DAY YEAR	2b. HOUR	
Howard				E.	Transue, Jr.		<input checked="" type="checkbox"/>			6/15/84 19	MONTH DAY YEAR	2d HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD				6/15/84 19		2d HOUR 10:30 P M	
Male	White	11 5 56	27										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
Maryland		USA					Baltimore City						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore		1300 Asbury (rear of garage) 21209			Laborer								
13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1320 Appleby Ave. 21209						
14. FATHER'S NAME FIRST Howard		MIDDLE E.	LAST Transue, Sr.	15. MOTHER'S MAIDEN NAME FIRST Julia		MIDDLE	LAST Maitz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		--		218-70-6745		Mrs. Donna Payne		1320 Appleby Ave. 21209					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intravenous Narcotism</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Gregory R. Kauffman, M.D.</u>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St., Balt., Md. 21201												DATE SIGNED 6/16/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Cremation 6/18/84		23c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery		23d. LOCATION CITY OR TOWN Baltimore		COUNTY		STATE Maryland			
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.		ADDRESS 3818 Roland Ave. 21211		25. DATE REC'D BY REGISTRAR JUN 19 1984		25. REGISTRAR John Davidson, R.N.							
BP													
DHMH - 17													
(VR A15 ME (5))													
20M 4/82													

RECORDED

REC'D U.S. MAIL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 FOR BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16382					
1- STATE REGISTRAR			2. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 6-27-84 ₁₉									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST PORTER			MIDDLE CLAYTON			LAST TRICE			3c. DEATH ESTI- MATED <input type="checkbox"/>					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-27-84 ₁₉		2d. HOUR 3:50P M			
MALE		WHITE		10 04 55		28											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
MARYLAND			U.S.A.														
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1500 S. Monroe Street									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSEMAN			12b. KIND OF BUSINESS OR INDUSTRY MONTGOMERY WARD		
13. STATE MARYLAND			13b. COUNTY A.A.		13c. CITY OR TOWN PASADENA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21122 7850 MANSION HOUSE CROSSING							
14. FATHER'S NAME FIRST PORTER			MIDDLE CHARLES		LAST TRICE			15. MOTHER'S MAIDEN NAME FIRST CLARA			MIDDLE L.		LAST EDWARDS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 1974-1978			16c. ADDRESS SHEILA S. TRICE 105 9TH AVENUE, 21225			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8122 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR: 3:45 AM MONTH: JUNE DAY: 6-27-84 ₁₉ YEAR: 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of motorcycle/tractor trailer collision subject ejected and run over by tractor trailer			21d. LOCATION STREET: 1500 S. Monroe St. CITY OR TOWN: Baltimore, Maryland COUNTY: Maryland STATE:								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street														
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Margarita A. Korell, M.D. TITLE (SPECIFY) M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED 6-28-84																	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn Street														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 06-30-84			23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL			23d. LOCATION CITY OR TOWN BROOKLYN PK. COUNTY A.A. STATE MARYLAND								
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 21229 4107 WILKENS AVE.						25a. DATE REC'D. BY REGISTRAR JUN 29 1984			25b. REGISTRAR'S SIGNATURE Gina Wilson					
20 BMH - 17 (VR A15 ME (5)) 20M 4/B2																	

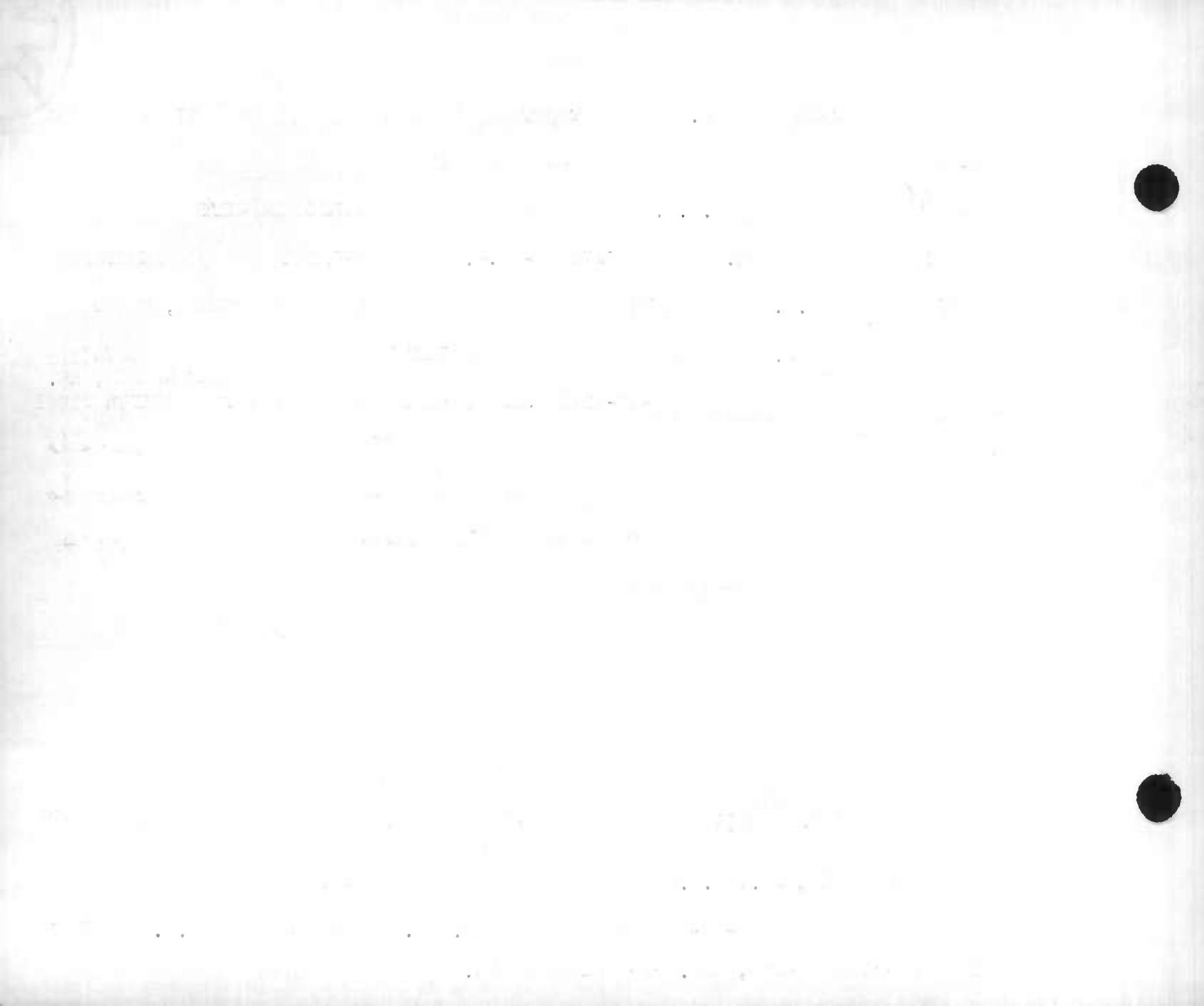


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 6 3 8 3			
										REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
			ARTHUR C. TROST						06 27 84		9:15A M		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE			WHITE			04 07 13			71 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND			U.S.A.						BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE			ST. AGNES HOSPITAL - E.R.			CARRIER			NEWSPAPER				
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MARYLAND			A.A.			LINTHICUM			202 HANCE AVENUE, 21090				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			ADDRESS							
ADOLPH J. TROST			HARRIETTE			GLEN BURNIE, MD.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			216-32-7271			JOHN & MARY RAYNER			seconds				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			sudden cardiac death						seconds				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) myocardial ischemia						seconds				
			DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease						yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Calvin Plitt</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/26/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CALVIN PLITT, JR., M.D.			22e. ADDRESS 7401 OSLER DRIVE, 21204										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 06-29-84			23c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN MEM. PK. 21229			23d. LOCATION CITY OR TOWN GLEN BURNIE			COUNTY STATE A.A. MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR JUN 29 1984			25b. REGISTRAR'S SIGNATURE <i>John W. Hubbard Jr.</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with this certificate until 24 hours after death, when they will be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 3 4 1 6 3 8 4													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
JOSEPH			John			TROVATO			June 9 1984			8:35 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
MALE		WHITE		Feb. 3, 1906			78						
7a. BIRTHPLACE (COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City			MD.			
10. CITY OR TOWN OF DEATH Baltimore		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS) Church Home Hosp.		11a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Welder (ret)			11b. KIND OF BUSINESS OR INDUSTRY G.M.						
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 310 Margate Drive (21061)				
14. FATHER'S NAME Orizo			MIDDLE LAST			15. MOTHER'S MAIDEN NAME Consetta			MIDDLE			(UNKNOWN)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. xxxxxxxxxx			17. INFORMANT Mary M. Trovato (wife) same as 13			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pneumonia</u> <u>3310</u> DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days	
} DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's Disease</u> months													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from <u>JUNE 2</u> , 19 <u>84</u> , to <u>JUNE 9</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> we last saw the deceased alive on <u>JUNE 9</u> , 19 <u>84</u> , and that <input checked="" type="checkbox"/> our opinion death occurred on the date and hour and from the causes stated above. We did not witness the body after death.													
22b. SIGNATURE <u>John Mannisi</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/9/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Mannisi M.D.			22e. ADDRESS Church Hospital 100 N. Broadway Baltimore Md. 21231										
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 13 June 84			23c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Mem Pk.			23d. LOCATION GLEN BURNIE AA MD STATE				
24. FUNERAL DIRECTOR Name Singleton Funeral Home, Glen Burnie, MD			Address			25a. DATE REC'D. BY REGISTRAR JUN 12 1984			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Pashell</u>				

(1000)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 4 1 6 3 8 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GARY BOY TUCKER			MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR 6 7 84	MONTH DAY YEAR	2b. HOUR 0200H
3. SEX M	4 RACE B	5. DATE OF BIRTH MONTH DAY YEAR 6 6 84			6. AGE (IN YEARS LAST BIRTHDAY) 4 ½ hours YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN. 4 30
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U OF MD. HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY CITY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 107 S. BEACHFIELD AVE.		
14. FATHER'S NAME FIRST ✓		MIDDLE ✓	LAST ✓	15. MOTHER'S MAIDEN NAME FIRST KAREN		MIDDLE	LAST TUCKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT DR. S. RAJASINGHAM		ADDRESS - 22 GREENE ST. BALTIMORE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 7651 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET 616		CITY OR TOWN 617	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 6/7 , 19 84 , to 6/7 , 19 84 , that (II) (we) last saw the deceased alive on 6/7 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. Rajasingham MD		DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 6/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJASINGHAM		22e. ADDRESS 22 GREENE ST., BALTIMORE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/14/84	23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN BALTO., MD.			23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE JUN 19 1984 The Davidson-Hendelle					

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standard deviation standard error

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner may be consulted before death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 4 1 6 3 8 6						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
GERTRUDE C. TURANSKY												JUNE 25, 1984				10:50 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS			
Female			White			MONTH 12 DAY 6 YEAR 1911			72 YRS.			MONTHS			DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.						Baltimore City									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore			Church Hospital Corporation			Housewife												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Baltimore									12925 Loyola Road			21220			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME												
Francis						Frances												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO			213-07-1933			Doris L. Golembieski			Same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC CONGESTIVE HEART FAILURE																		
DUE TO, OR AS A CONSEQUENCE OF (b) ATERIOSCLEROTIC CARDIOVASCULAR DISEASE																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
CARDIAC CIRRHOSIS WITH ENCEPHALOPATHY																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (the hospital) attended the deceased from JUNE 15, 19 84, to JUNE 25, 19 84, that (I) (we) did saw the deceased alive on JUNE 25, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																		
22b. SIGNATURE <i>A. R. Nazemi MD</i>															22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			CHURCH HOSPITAL CORPORATION			22f. DATE SIGNED 6/25/84									
A. R. NAZEMI, M.D.						100 N. BROADWAY, BALTIMORE, MD. 21233												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 6/29/1984			23c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary			23d. LOCATION CITY OR TOWN Dundalk			COUNTY Balto.			STATE Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.			ADDRESS 7922 Wise Avenue			25a. DATE REC'D. BY REGISTRAR JUN 28 1984			25b. REGISTRAR'S SIGNATURE <i>John Pendell</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	8 4 1 6 3 8 1	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Mrs. Oleine Turner									June 3 1984			10:30 AM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			Caucasian			January 25 1896			88 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
North Carolina			U.S.A.						Baltimore City					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL GIVE STATE AND CITY)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			John L. Deaton Medical Center						Teacher-Girard			College Pa.		
13a. STATE Maryland			13c. CITY OR TOWN Carroll			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4608 London Bridge Road 21784					
14. FATHER'S NAME FIRST MIDDLE LAST James McLeman			15. MOTHER'S MAIDEN NAME Sally Hardee McLeman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (YES, GIVE WAR OR DATES) No 199-28-6446			17. INFORMATION Mrs. Jean Mulholland 4608 London Bridge Road Sykesville Maryland			ADDRESS 21784					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2989 IMMEDIATE CAUSE (a) Bilateral pneumonia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1wk.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) Unresponsive mental status/dementia									1-2 mo.		
			DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Colon Ca, stroke, cholecystitis, anemia, basal cell Ca of face.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from May 30, 1984, to June 1, 1984, that (1) (we) last saw the deceased alive on June 1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Steven Luke MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED June 4, 1984					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Luke			22e. ADDRESS 22. S. Greene St. Baltimore MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 06-06-84			23c. NAME OF CEMETERY OR CREMATORIAL Ward's Chapel Cemetery			23d. LOCATION CITY OR TOWN Randallstown			COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133									25a. DATE REC'D. BY REGISTRAR 1984			25b. REGISTRAR'S SIGNATURE Loring Randall		

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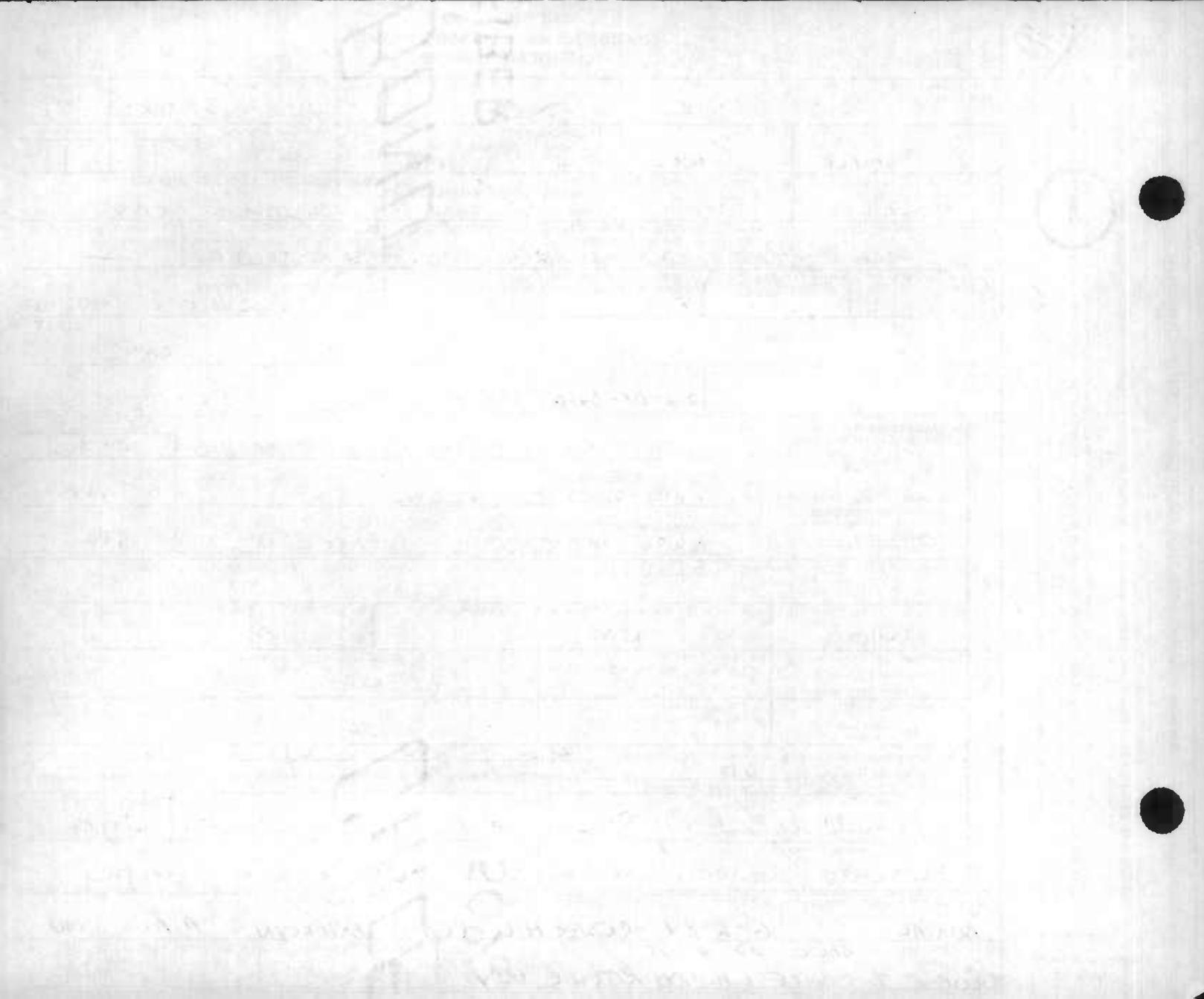
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the hospital or attending physician.

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, no medical examination shall be done.

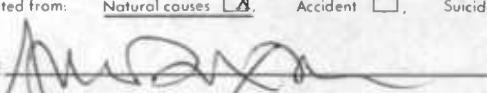
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4	1 6	3 8	8						
										REG. NO.									
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR									
I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		JUNE 3 1984		120 A.M.								
ADA FISK TYLER																			
3. SEX FEMALE			4. RACE CAUC.			5. DATE OF BIRTH MONTH DAY YEAR 4 3 1890			6. AGE (IN YEARS (LAST BIRTHDAY)) 94 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			8. CITIZEN OF WHAT COUNTRY? US			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			MD.							
10. CITY OR TOWN OF DEATH BALTIMORE CITY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP.							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BANK TELLER			12b KIND OF BUSINESS OR INDUSTRY -						
13a STATE MD			13b COUNTY A.A.			13c CITY OR TOWN BROOKLYN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 230 W. EDGEVALE RD BALTO MD 21225							
14. FATHER'S NAME FIRST LOUIS			MIDDLE FISK			15. MOTHER'S MAIDEN NAME FIRST MARGARET LOUISE			16. SOCIAL SECURITY NO. 312-01-0296			17. INFORMANT MARY LEITZ			ADDRESS 230 W. EDGEVALE RD. 21225 BALTO MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 SEPSIS FROM GRAM NEGATIVE ORGANISM										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIOGENIC SHOCK										7 DAYS									
(c) ACUTE MYOCARDIAL INFARCTION										9 DAYS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) NA													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA			21f. LOCATION STREET NA			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5/24 1984 to 6/3 1984 , that (II) (we) last saw the deceased alive on 6/3 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Florante Richard Y. Mancas			22c. DEGREE MD							22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 6/3/84						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) FLORANTE RICHARD MANCAS			22f. ADDRESS SOUTH BALTIMORE GEN. HOSPITAL																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-6-84			23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEM.			23d. LOCATION CITY OR TOWN BROOKLYN			COUNTY A.A.		STATE MD.					
24. FUNERAL DIRECTOR NAME GEORGE J. GONCE F.H. 400 RITCHIE HWY.			25a. DATE REC'D. BY REGISTRAR JUN 4 1984							25b. REGISTRAR'S SIGNATURE John Davidson-Randall									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN IN PAGE 5 FOR YOUR USE. **PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN IN PAGE 5 FOR YOUR USE.** **PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN IN PAGE 5 FOR YOUR USE.** **AFTER DEATH, WITH THE STATE BOARD OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.**

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6389		
1 - STATE REGISTRAR														
I. DECEASED NAME (TYPE OR PRINT)		FIRST PAUL	MIDDLE ELLSWORTH			LAST TYLER			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 25 1984		2b. HOUR M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5-4-1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 25 1984		2d. HOUR 5:26 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City								
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3505 Elmley Ave.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE			12b. KIND OF BUSINESS OR INDUSTRY U.S. POST OFFICE
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 3505 ELMLEY AVE. 21213						
14. FATHER'S NAME FIRST UNKNOWN		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST MARY		MIDDLE		LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR GATES) WW I 220-40-3750			17. INFORMANT CARLYN TYLER (WIFE)			ADDRESS SAME ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>														
(b) _____ DUE TO, OR AS A CONSEQUENCE OF														
(c) _____ DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant	MEDICAL EXAMINER	DATE SIGNED 6-26-84
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 PENN St., Balto., Md. 21201												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6/28/84		23c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD			23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY	STATE				
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home Inc.		25a. DATE REC'D. BY REGISTRAR 21213 29 1984			25b. REGISTRAR'S SIGNATURE Lelia Davidson-Rendell									
BP _____														
DHMH - 17 (VR A15 ME (5))														
20M 4/82														

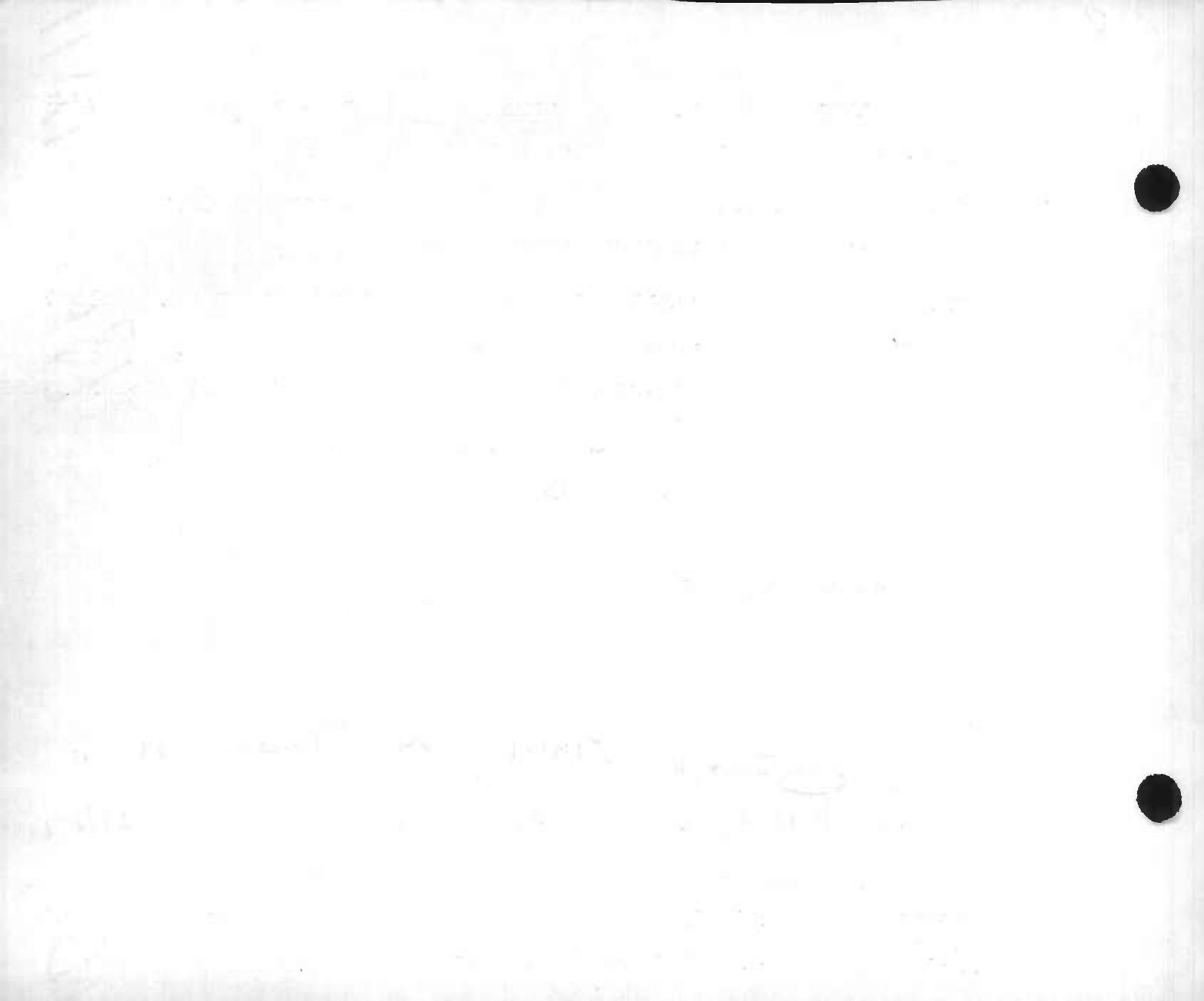
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical certificate must be signed or once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 3 9 0	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			ANNA B. URBAN						JUNE 20 1984			6:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		DEC. 8 1896			87 YRS.			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY			
MD.		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		GARDEN VILLAGE NURSING HOME			HOMEMAKER								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD.		-		BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7426 REMOOR RD.			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ALBERT				TUMA			MARY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
NO				218-44-9310			MILDRED HAMILTON (NIECE) SAME ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS CVD</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c)													
DUE TO, OR AS A CONSEQUENCE OF													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Senile Dementia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 1 1984</i> to <i>JUNE 20 1984</i> , that (I) (we) last saw the deceased alive on <i>JUNE 11 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>6/21/84</i>	
22b. SIGNATURE <i>Howard Bond</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Dr. Howard Bond		9618 Belair Rd.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY COUNTY STATE						
BURIAL		6/23/84		HOLY REDEEMER			BALTIMORE			MD.			
24. FUNERAL HOME SCHITTMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Baltimore, Md. 21213		25a. DATE REC'D. BY REGISTRAR 11IN 22 1984			25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Pendell</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 3 9 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
Margaret A. Valentine						June 19, 1984				2 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		Black		MONTH	DAY	YEAR	70								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Delaware		USA					Baltimore City								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		26 N. Rosedale St.													
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 26 N. Rosedale St. 21229							
14. FATHER'S NAME FIRST Frank		MIDDLE L.		LAST Granger		15. MOTHER'S MAIDEN NAME FIRST Ida		MIDDLE E.		LAST Mosley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT ADDRESS											
No		217-01-3132		James Harrell 3011 W. Belvedere Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cervical Carcinoma</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma, Colon</u>															
{ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Obstructive Lung Disease, Cervical Carcinoma</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6-13</u> , 19 <u>84</u> , to <u>6-19</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Alan Adelman, MD</u>		DEGREE			ATTENDING PHYSICIAN		<input type="checkbox"/> DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED <u>6/20/84</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alan Adelman, MD</u>		22e. ADDRESS <u>600 Light St Baltimore, MD 21230</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/23/84		23c. NAME OF CEMETERY OR CREMATORIUM Silver Lake Cem.			23d. LOCATION CITY OR TOWN Dover		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR <u>JUN 20 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Lia Davidson-Pandell</u>								

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-trust permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical certifying physician must be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 6 3 9 2				
										REG. NO.				
1 - FOR STATE REGISTRAR			MILDRED GRANT VANBRUNT			2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			MILDRED GRANT VANBRUNT			June 28, 1984								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
F		W		MONTH Oct. DAY 24, YEAR 1895			88			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
New Jersey		USA					Baltimore City,			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Ardley Nursing Home		Nurse Aid			Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Md.				Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5405 N. Charles St. 21210				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME										
		George Wagner		Martha Ann Jones										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
No		110 26 2523		Rev. F. Norman VanBrunt			Pennsville, N. J.							
18. CAUSE OF DEATH (Enter only one cause per line for Part I and II.) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (o) <i>Atherosclerosis generalized</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.</i>								7 years				
		DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								7 yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Diverticulitis of colon with hemorrhage</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i></i> CITY OR TOWN <i></i> COUNTY <i></i> STATE <i></i>									
22a. I certify that (I) (this hospital) attended the deceased from <i>March 28, 1977</i> to <i>June 28, 1984</i> , that (II) (we) last saw the deceased alive on <i>June 27, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>W. Grafton Hersperger</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. Grafton Hersperger</i>		22f. ADDRESS Medical Arts Bldg.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 29, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Cem.			23d. LOCATION Baltimore, Md.			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.		ADDRESS 6500 York Rd.			25a. DATE REC'D. BY REGISTRAR JUL 3 1984			25b. REGISTRAR'S SIGNATURE <i>Julie Dawson</i>						

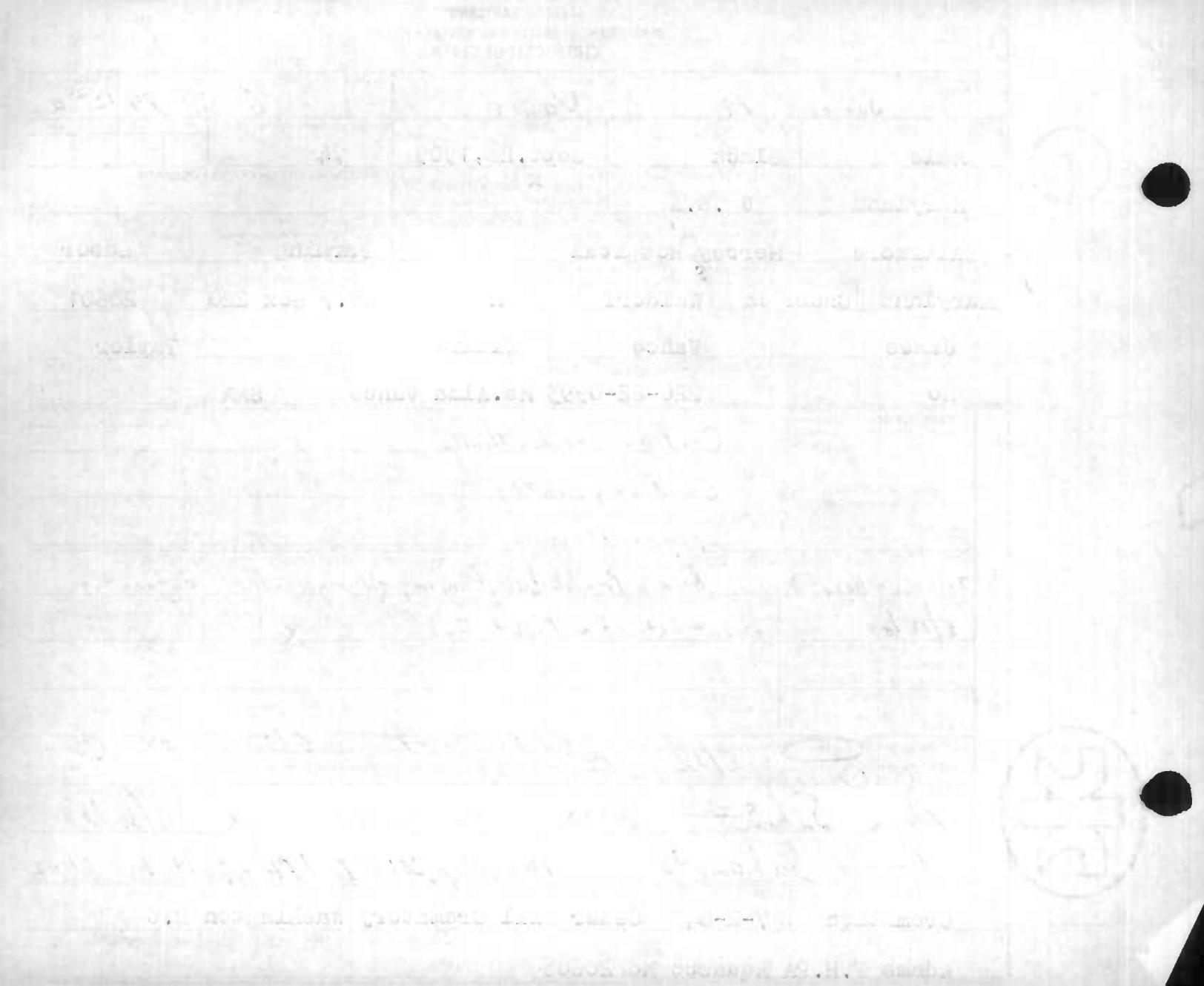
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.
 IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 1 6 3 9 3				
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 12 ²⁰ a.m.		
			James M Vance						6 30 84					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Black		Sept. 28, 1909			74			YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD. City			
Maryland		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Mercy Hospital						Farming			Labor			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Charles		Waldorf						Rt. 7 Box 220			20601	
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James				Vance			Willie			Taylor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No				220-22-0993			Ms. Alma Vance			SAA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiacopathy</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION 6/22/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cataract Extraction Right Eye			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I, this hospital) attended the deceased from 6/30 19 84 to 6/13 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did/did not) view the body after death.										22c. DATE SIGNED 6/30/84				
22b. SIGNATURE <u>Ronald Sakamoto</u>										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22e. ADDRESS Mercy Hosp, 301 St Paul Place, Bc 14. MD 21202														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Cremation 7-2-84		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory			23d. LOCATION Washington D.C.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Adams F.H.P.A Aquasco Md 20608		ADDRESS			25. DATE RECEIVED BY REGISTRAR JUL 19 1984			25b. REGISTRAR'S SIGNATURE John J. Johnson						



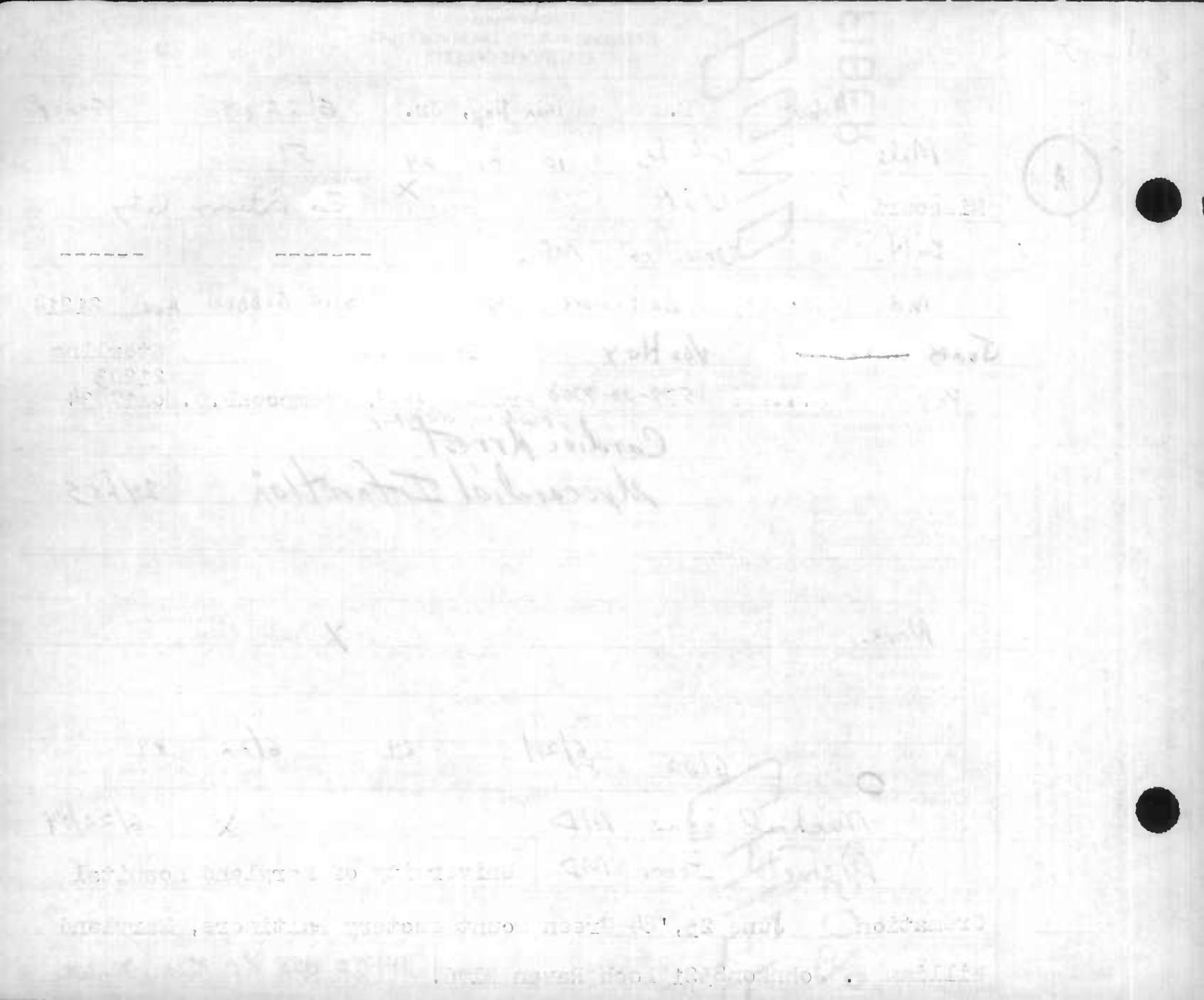
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3), then please return carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT!) If item 21a is marked on Item 18, shown any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8416394		
										REG. NO.		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	6/22/84			5:20 PM			
Hubert E. Van Hoy, Jr.												
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White		10 01 24		59 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Missouri			USA				Baltimore City					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Balt.			Univ. of Md.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Md. 13b. COUNTY 21214 13c. CITY OR TOWN Baltimore							13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3114 Gibbon Ave 21214
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James				Van Hoy	Inez							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
Yes			W.W. II		579-20-7308		Frederick J. Thompson P.O. Box 17034			21203		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction										24 hrs		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6/21/84 to 6/22/84, 19 84, to 6/22/84, 19 84, that (I) (we) lost saw the deceased alive on 6/22/84, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Michael Econ MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							22c. DATE SIGNED 6/22/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Econ MD			22e. ADDRESS University of Maryland Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE June 25, '84			23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME William E. Johnson			ADDRESS 521 Loch Raven Blvd.			25a. DATE REC'D. BY REGISTRAR JUN 25 1984			25b. REGISTRAR'S SIGNATURE John David Pendell			



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 PLEASE FOR DIRECTOR
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGES 1, 2, 3, 4 FOR FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED IN WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16395	
1. DECEASED NAME (TYPE OR PRINT) M JOHN VENEZIALE			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 23 1984			2b HOUR 2d 8:53 a.m.				
3. SEX M	4. RACE White	S. DATE OF BIRTH MONTH Ja. 3 YEAR 07	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. IF UNDER 24 HRS. HOURS 0	10. IF UNDER 24 HRS. MIN. 0	2c. DATE PRONOUNCED DEAD MONTH 6 DAY 23 YEAR 1984			2d HOUR 8:53 a.m.		
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			12b. KIND OF BUSINESS OR INDUSTRY Truck		
11. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chaurier				
12a. STATE Md.	12b. COUNTY Balto.	13c. CITY OR TOWN Arbutus	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1118 Vernon Avenue 21227							
14. FATHER'S NAME FIRST Anthony MIDDLE veneziale LAST			15. MOTHER'S MAIDEN NAME FIRST Pasqaula MIDDLE DilLenardo										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 147-09-9119			17. INFORMANT Mrs. Viola M. Veneziale			ADDRESS 1118 Vernon Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE  EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												TITLE (SPECIFY) M.D. Assistant	
ADDRESS 111 Penn St., Balto., Md. 21201												DATE SIGNED 6-25-84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/26/84			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge			23d. LOCATION CITY OR TOWN Dorsey			COUNTY Howard	STATE MD.
24. FUNERAL DIRECTOR NAME Ambrose F.H.			25a. DATE REC'D. BY REGISTRAR ADDRESS 1328 Sulphur Spring			25b. REGISTRAR'S SIGNATURE Ridson Rendell			25c. DATE REC'D. BY REGISTRAR 6-25-1984				
BP			DHMH - 17 (VR A15 ME (5))			20M 4/82							



RECEIVED
4010



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS INCURRED IN PLEASING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 3 9 6			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2d. HOUR	
Anna				Lucille Evans			<input checked="" type="checkbox"/>				6/14/84 19				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	7c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR
F	B	OCT 24 1926	57 yrs.					<input checked="" type="checkbox"/>				6/14/84 19			7:50 AM
BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.
Md				U.S.							Baltimore City				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				University Hospital Shock Trauma				Laborer				SafFood			
13a. STATE Md				13b. COUNTY Som.		13c. CITY OR TOWN Crisfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 146 Locust St, 21817					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME Anna								LAST			
Harley Evans												Miles			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 213-22-5692				17. INFORMANT Mary Ward Evans - Phila, Pa.				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Cranio-cerebral Trauma												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR xx MONTH DAY YEAR 6:08 P.M. 6/12/84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject pedestrian struck by auto							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET 4th St., & Main St., Crisfield, Md.				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED 6/14/84			
Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St., Balto., Md. 21202											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 16/20/84				23c. NAME OF CEMETERY OR CREMATORIAL Hopewell				23d. LOCATION CITY OR TOWN Hopewell/ Som Md			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR JUN 15 1984				25b. REGISTRAR'S SIGNATURE Lisa Davidson Pendell			
BP															
DHMH - 17 (VR A15 ME (5))															
20M 4/82															



1903 3 1 WU

ATTENDING PHYSICIANS IN HOSPITALS

EDUCATIONAL EXAMINERS' OFFICE

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8416391					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MILDRED					WALKER					JUNE 13, 1984				3:45A M	
3. SEX <i>Female</i>		4. RACE <i>Negro</i>			5. DATE OF BIRTH <i>8 23 29</i>					6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i>	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
										YRS. <i>55</i>	DAYS		MIN.		
7a. BIRTHPLACE <i>M.D.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i>					
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>JOHNS HOPKINS HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Labor</i>						12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>M.D.</i> 13b. COUNTY <i>BALTO.</i> 13c. CITY OR TOWN <i>BALTO.</i>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2400 E. Preston St 21213</i>			
14. FATHER'S NAME <i>R.T.</i>		15. MOTHER'S MAIDEN NAME <i>Mamie Wilson</i>			16. SOCIAL SECURITY NO. <i>433-44-9475</i>		17. INFORMANT <i>Mr. Clawzell Bailey</i>			ADDRESS <i>2400 E. Preston St</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory</i> Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>mm</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Metastatic lung cancer</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>6/10</i> , 19 <i>84</i> , to <i>6/13</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>6/12</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.															
22b. SIGNATURE <i>George Bettas</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>6/13/84</i>							
22e. PHYSICIAN'S NAME, TITLE OR PRINT <i>George Bettas</i>		22f. ADDRESS <i>50 Johns Hopkins Hosp</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>6/18/84</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>BALTO. Cem.</i>		23d. LOCATION CITY OR TOWN <i>BALTO.</i>		23e. COUNTY				STATE <i>M.D.</i>			
24. FUNERAL DIRECTOR <i>George Bettas Funeral Home 1129 N Charles St</i>		25a. ADDRESS <i>1129 N Charles St</i>			25b. DATE REC'D. BY REGISTRAR <i>JUN 15 1984</i>			25c. REGISTRAR'S SIGNATURE <i>Julia Davidson Randsell</i>							



RECORDED - SEARCHED - SERIALIZED - INDEXED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 3 9 8		
1- STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH (ESTIMATED) MONTH DAY YEAR			2b. HOUR		
			Roland Walker						6/12/84 19			11:20 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR		
Male		Black		8-3 -1909		823						6/12/84 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		USA						Baltimore City						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		4202 Pimlico Rd.						Retired						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Md.				Balto.				4202 Pimlico Rd. 21215						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Wilburn		Walker		Annie		Walker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
no				Elise Garnes 237 Douglass Ct.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6-19-84		23c. NAME OF CEMETERY OR CREMATORIAL Church Cem.		23d. LOCATION CITY OR TOWN South Hill		COUNTY Mecklenburg		STATE Va				
Burial														
24. FUNERAL DIRECTOR NAME		ADDRESS Chas. A. Rice FSPA 1300 Eutaw Pl		25a. DATE REC'D. BY REGISTRAR JUN 19 1984		25b. REGISTRAR'S SIGNATURE								
BP														
DHMH - 17 (VR A15 ME (5)) 20M 4/82														

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS OF DEATH. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6 399			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR	
RONNIE LEE WALLACE							<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6	24	1984	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	7c. DATE PRONOUNCED DEAD				7d. HOUR	
M	B	May 11- 1955	29							6	24	1984	4:15 a.m.		
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
MD		U.S.A.				Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		University Hospital (DOA)						Custodian- Bd. of Ed. A.A.C.O.						MD.	
13a. STATE		14. COUNTY		15. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
MD		A.A.		SEVERN				1160 Reese Road		21144					
15. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
WILTON				WALLACE		DOROTHY		VIRGINIA		JOHNSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		213-64-0984		Dorothy V. Johnson		1661 Circle Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Multiple gunshot wounds (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
						<input checked="" type="checkbox"/>		<input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE			
		home		1160 Reese Rd., Severn,		Anne Arundel									
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201		TITLE (SPECIFY)		Assistant M.D.		MEDICAL EXAMINER	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE			
Burial		6-28-84		Mt. ZION Church Cem.		LOTHIAN, A.A.C.O. Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
C.E.HICKS 111 -1922 Forest Dr. Annapolis, Md.				JUN 26 1984		John Davidson Pendell									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 4 1 6 4 0 0

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
George H. Walsh, Jr.						June 11, 1984				M	
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Black	7	28	23	60					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.						Baltimore City MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		1904 N. Pulaski Street									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Maryland				Baltimore				1904 N. Pulaski St. 21217			
14 FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
George			Walsh	Lucy							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
YES		218-18-7073			Vivian Walsh			1904 N. Pulaski Street			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic laryngeal carcinoma.</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 19 83</u> to <u>June 11, 1984</u> , that (I) (we) last saw the deceased alive on <u>June 9, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED		
George Taler, M.D.							<input type="checkbox"/>	<input type="checkbox"/>	6/13/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
George Taler, M.D.		600 Light St. Balt. Md. 21230									
23a BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/15/84		23c. NAME OF CEMETERY OR CREMATORIUM Md. Veteran Cem.		23d. LOCATION TOWNSHIP		CROWNsville, COUNTY		Md.	
24 FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue			25a. DATE REC'D. BY REGISTRAR JUN 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendelle				

a



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be searched within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8416401			
1 - FOR STATE REGISTRAR			I. DECEASED NAME FIRST RUTH MIDDLE LUCILLE LAST WALSH			2a. DATE OF DEATH 6 13 84			MONTH DAY YEAR		2b. HOUR 1130A.M.		
II. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 07 DAY 12 YEAR 10			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON			12b. KIND OF BUSINESS OR INDUSTRY BAKERY					
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN ARBUTUS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4315 WILKENS AVE. APT. C 21229					
14. FATHER'S NAME FIRST JOSEPH MIDDLE HEDDINGER LAST		15. MOTHER'S MAIDEN NAME FIRST EMMA MIDDLE LAST SOUTHWORTH											
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-09-3530			17. INFORMANT FRANCIS P. WALSH			ADDRESS 4315 WILKENS AVE. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 WKS			
4039 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE, CHRONIC (c) DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE, SEVERE ASCVD, HTN													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. DIABETES MELLITUS, ANEMIA													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Gaurav Malhotra</i> DEGREE										22c. DATE SIGNED 6.13.84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. MALHOTRA</i>		22e. ADDRESS ST AGNES HOSP. BALTIMORE MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-16-84		23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK			23d. LOCATION CITY OR TOWN BALTIMORE CITY		COUNTY MARYLAND STATE				
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR JUN 15 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					



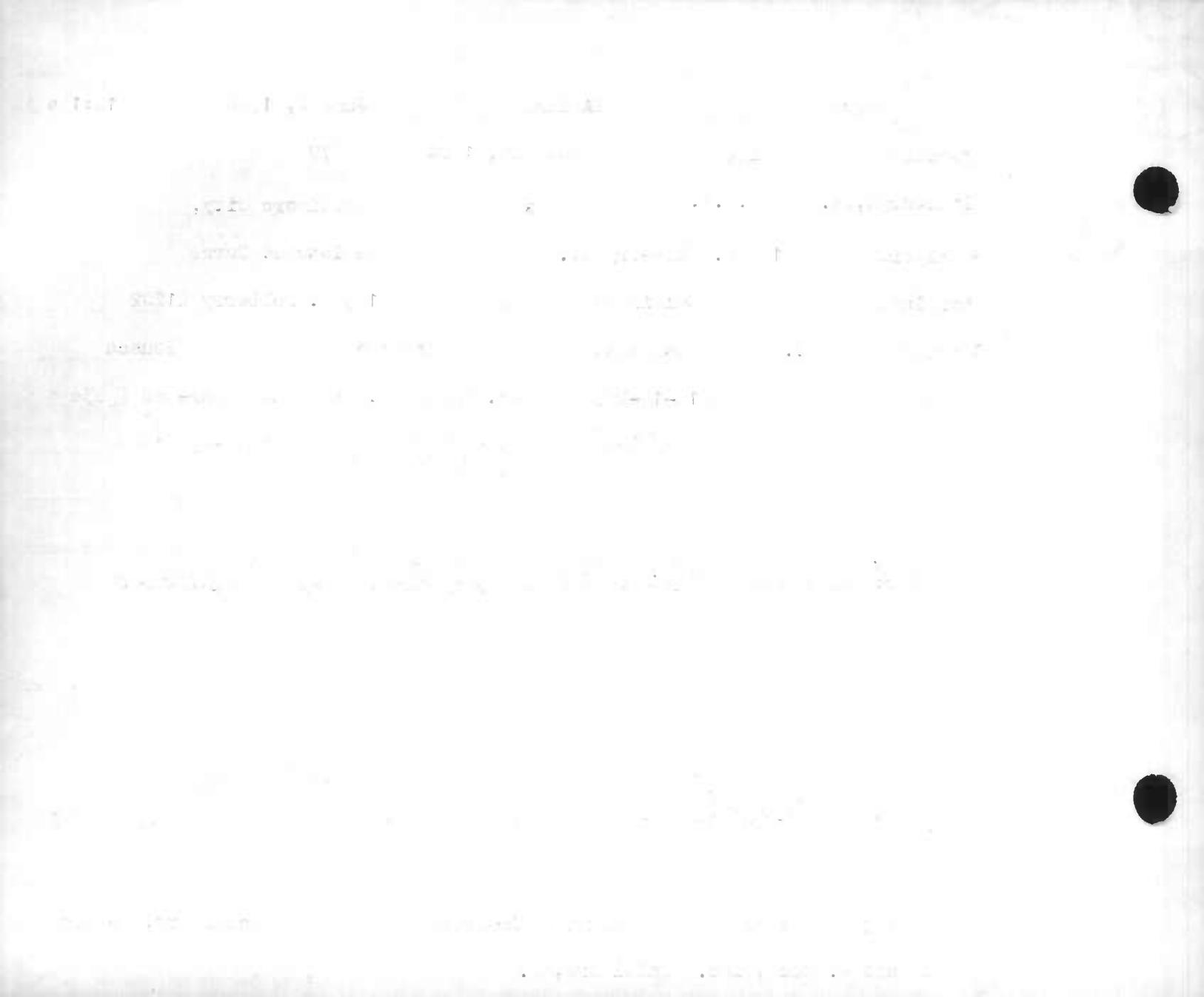
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of being retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified before issuing a death certificate.

Page 4 may be

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 4	6 4 0 2		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
ALICE					WALTERS	June 2, 1984						10:15a M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White			MONTH DAY YEAR			79			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Pittsburgh, Pa.			U.S.A.									Baltimore City,			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore			103 E. Mulberry St.			Registered Nurse									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland						Baltimore						103 E. Mulberry 21202			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
Charles			J.	Parlette	Henrietta					Peusch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-18-2695			17. INFORMANT Mr. Thomas E. Parlette			ADDRESS Same as # 13e			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			Astenosclerotic cardiovascular disease.												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF									
(c)						DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) chronic Obstructive Pulmonary Disease.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive, an _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Eric Fisher M.D.</i>												DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	23c. DATE SIGNED <i>6/4/84.</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Maryland General Hosp Baltimore, Md									
Eric Fisher M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Cremation			June			Westview Cemetery			Baltimore, Maryland						
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Leonard J. Ruck, Inc.			Baltimore, Md.			JUN 4 1984			<i>John Dawson</i>						



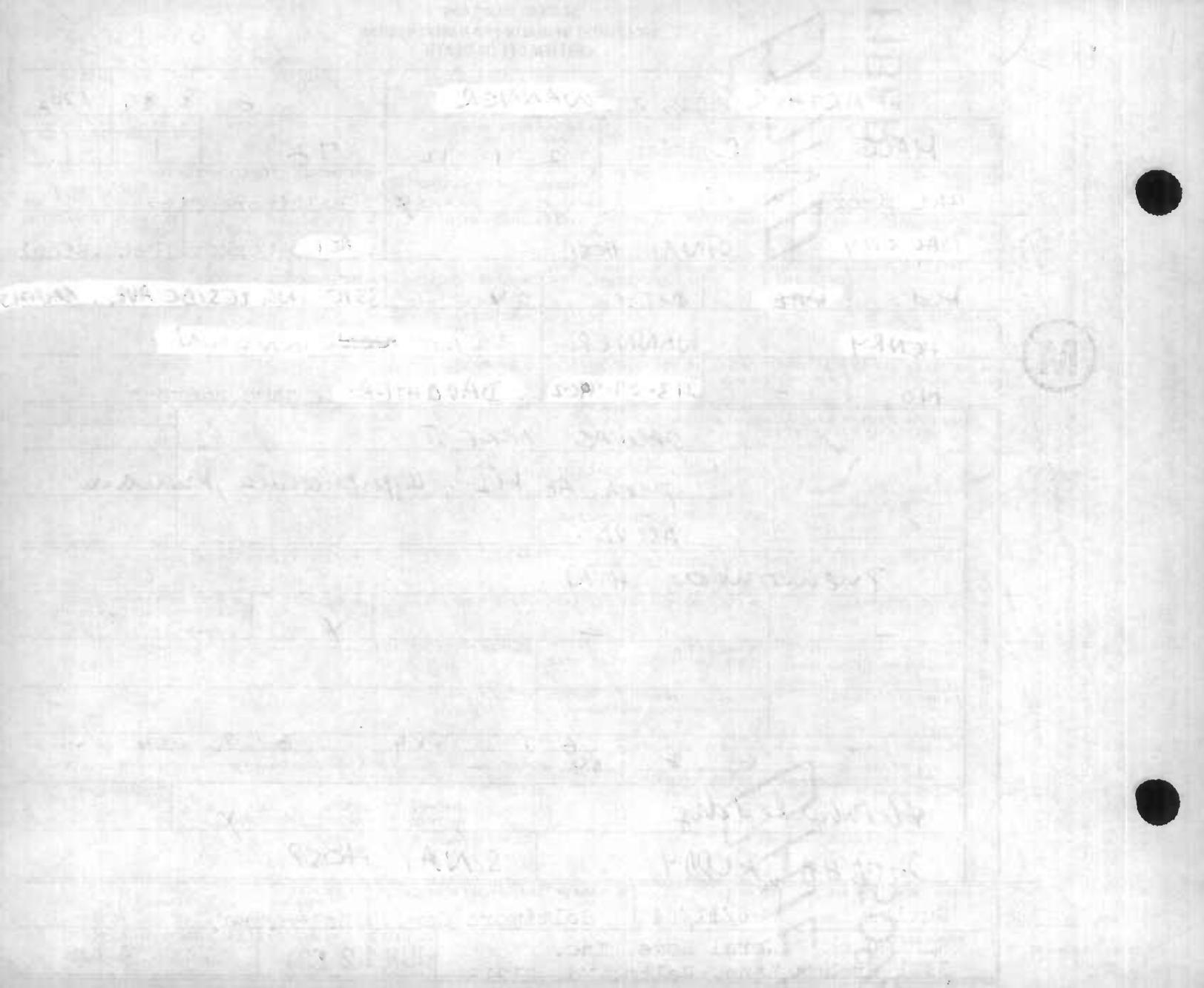
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please return to the deceased's physician with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical certifier must check here)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3416403	
1 - FOR STATE REGISTRAR				1a. DECEASED NAME (TYPE OR PRINT) ARTHUR H. WANNER, JR.				1b. DATE OF DEATH MONTH DAY YEAR 6 8 84				1b. HOUR 1:20 AM	
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 1 12			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7. BIRTHPLACE STATE OR FOREIGN COUNTRY Md. Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI Hosp.		12a. USUAL OCCUPATION Office Worker			12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel						
13a. STATE Md.		13b. COUNTY CITY		13c. CITY OR TOWN CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3510 Ingleside Ave. 21215			
14. FATHER'S NAME FIRST Arthur		MIDDLE		LAST WANNER			15. MOTHER'S MAIDEN NAME Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -		17. INFORMANT Marlene Martin, same address			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST - 4100												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF prof. Ac. MI ; Hypercalcemia, Pseudogout													
(c) DUE TO, OR AS A CONSEQUENCE OF ASCVD.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Pneumonia HTN.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (s) this hospital attended the deceased from 6-7-1984 to 6-8-1984, that (s) we last saw the deceased alive on 6-8-1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.													
22b. SIGNATURE Shobha Reddy		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHOBHA REDDY		22e. ADDRESS SINAI HOSP.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/11/84		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cem.			23d. LOCATION CITY OR TOWN Balto. Md.			COUNTY STATE			
24. FUNERAL DIRECTOR SCHIMUNEK Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR JUN 12 1984			25b. REGISTRAR'S SIGNATURE David Rendall						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign.

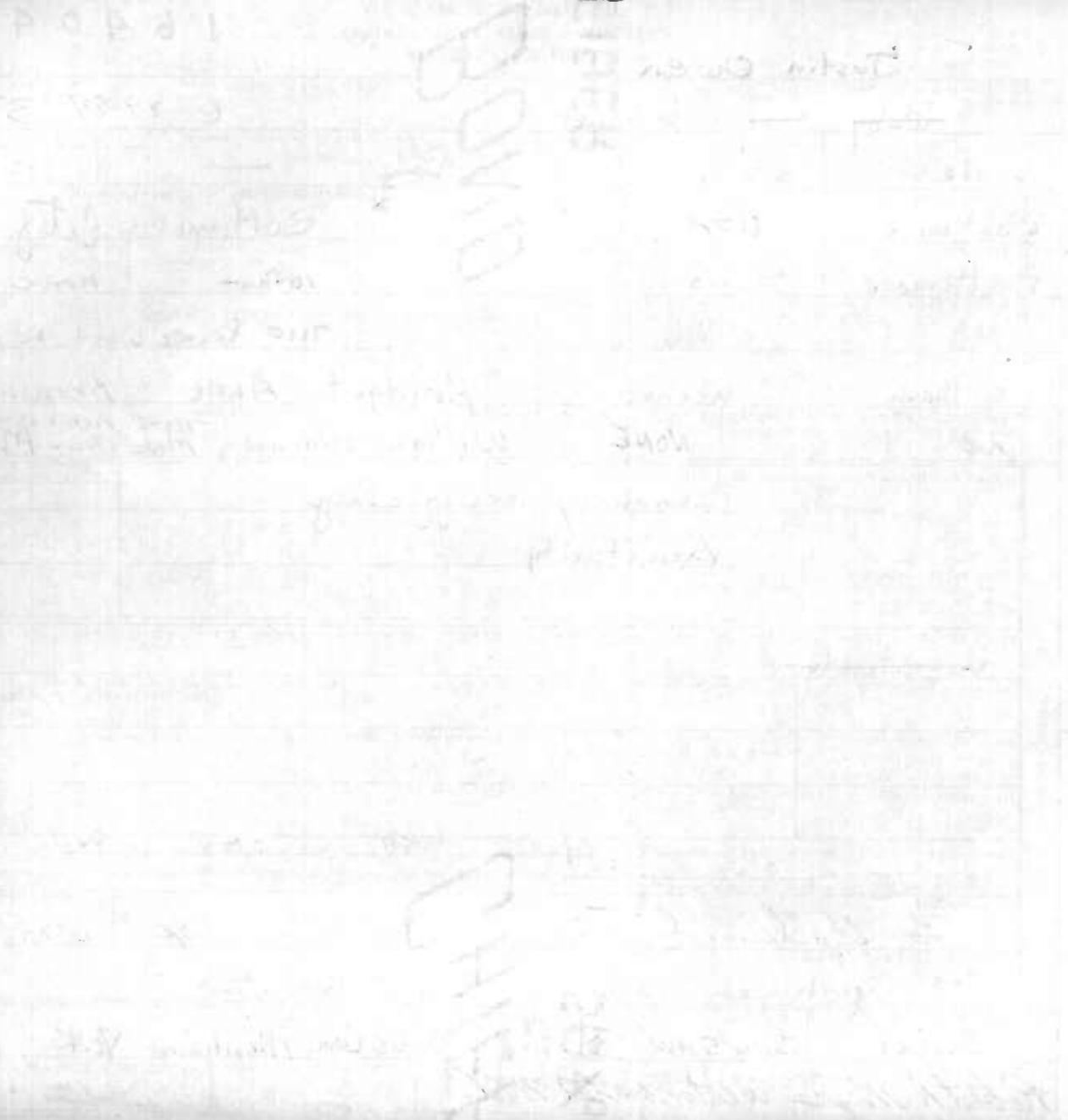
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16404			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Justin Owen					Warner		6-29-84		6	-29-	84	3:30 PM	
3. SEX		1	4. RACE		white		5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
male		1					6-29		84			IF UNDER 1 YEAR	
7b. BIRTHPLACE (COUNTRY)		Baltimore		7b. CITIZEN OF WHAT COUNTRY?		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD.	
10. CITY OR TOWN OF DEATH		Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Sinai		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Infant		12b. KIND OF BUSINESS OR INDUSTRY	
13c. STATE		MD		13d. COUNTY		Upchurch		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE		7110 Picnic Woods Rd / 21769	
14. FATHER'S NAME		FIRST	MIDDLE	LAST		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
william				Warner		Bridget Anne Brown		NONE		William Warner		711-0 Picnic Woods Rd Middletown Md 21769	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Prematurity													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/29 1984 to 6/29 1984, that (I) (we) last saw the deceased alive on 6/29 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we did not) view the body after death.													
22b. SIGNATURE B. Upchurch MD		DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/29/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Upchurch md		22e. ADDRESS Sinai Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 5, 1984		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Ubs Cem. Manheim York Pa		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
24. FUNERAL DIRECTOR Robert A. Myers Westminster Md.		25a. DATE REC'D. BY REGISTRAR July 10, 1984						25b. REGISTRAR'S SIGNATURE L. K. Krieger-Randall					
DHMH - 16 50M 4/83 (VRA 15, 4)													



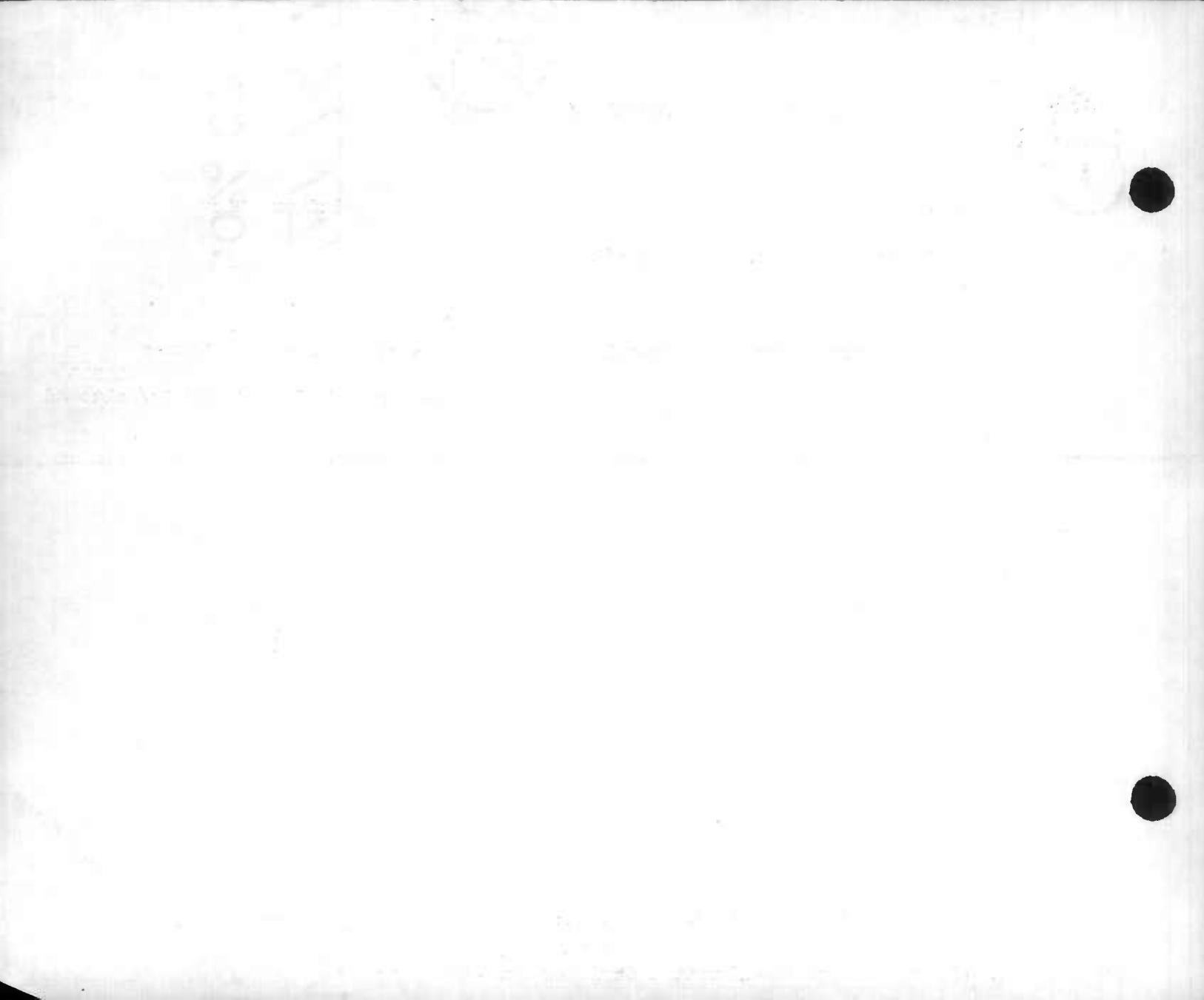
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called at any time.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Baby Boy				VENABLE	WARREN	6/11/84				11 ⁰⁹ P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS					
MALE	W	MONTH 6 DAY 11 YEAR 84	YRS.	MONTHS	DAYS	HOURS	MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	MD.							
Maryland	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore City								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Baltimore	St. Agnes Hospital										
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE							
Maryland		Baltimore	YES <input checked="" type="checkbox"/>	111 S. Gilmore St. 21223							
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	Janet	MIDDLE	Lee	LAST	Warren	
Aaron	Stewart		Venable	16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS				21223
						Janet Lee Warren/111 S Gilmore St/Balto Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7651</u> <u>immature fetus</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)	21f LOCATION STREET	CITY OR TOWN		COUNTY	STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>June 11</u> 19 <u>84</u> to <u>June 11</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>June 11</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											22c DATE SIGNED
22b SIGNATURE <u>R. Marcelli</u> DEGREE											22c DATE SIGNED
22e ADDRESS <u>St. Agnes</u>			22d DATE SIGNED								
22e PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. Marcelli</u>			22d DATE SIGNED								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORIUM	23d LOCATION CITY OR TOWN	23e COUNTY	STATE						
Cremation	06/15/84	Westview Crematorium	Catonsville, Md.	21228							
24 FUNERAL DIRECTOR NAME	ADDRESS			25a DATE REC'D. BY REGISTRAR							
Walters Funeral Home/Pratt & Stricker Streets	Balto Md 21223			25b REGISTRAR'S SIGNATURE							
JUN 15 1984 <u>J. L. Warren</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial and memorial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before the death certificate is filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4	16406
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Viola</i>	MIDDLE <i>R.</i>	LAST <i>Washington</i>	2a. DATE OF DEATH			MONTH <i>6</i>	DAY <i>26</i>	YEAR <i>84</i>	2b. HOUR <i>2⁰⁷ a.m.</i>	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH <i>1</i> DAY <i>5</i> YEAR <i>28</i>			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.			IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3036 Ascension St. 21230			
14. FATHER'S NAME FIRST Edward			MIDDLE 	LAST Wilson	15. MOTHER'S MAIDEN NAME FIRST Rebecca			MIDDLE 	LAST Norman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-26-6758			17. INFORMANT Claudette Thomas			ADDRESS 2708 Tivoly Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (Ventricular arrhythmia)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic lung cancer													
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first. (c) Metastatic lung cancer													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) this hospital attended the deceased from 6/26/84 to 6/26/84 , that (I) we last saw the deceased alive on 6/26/84 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did not view the body after death.													
22b. SIGNATURE <i>Ronald Sakamoto</i>		22c. DEGREE <i>and</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 6/26/84					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald Sakamoto		22f. ADDRESS Mercy Hosp, 301 St Paul/Mary, Balt, MD 21204											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/29/84		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Anne Arundel Co.		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Ave.			25a. DATE REC'D. BY REGISTRAR JUN 27 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson Pendell					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 3 4 1 6 4 0 1	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Chris Jean</i>	MIDDLE <i>waters</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR <i>6 29 84</i>	2b. HOUR <i>152 AM</i>
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 30 04</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>79</i>	7. IF UNDER 1 YEAR MONTHS DAYS <i>0 0</i>	8. IF UNDER 24 HRS HOURS MIN. <i>0 0</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW JERSEY</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>	12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <i>MARYLAND</i>	13b. COUNTY <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>3446 Park Heights Ave 21215</i>				
14. FATHER'S NAME FIRST <i>UNKNOWN</i>	MIDDLE <i>UNKNOWN</i>	LAST <i>UNKNOWN</i>	15. MOTHER'S MAIDEN NAME FIRST <i>UNKNOWN</i>	MIDDLE <i>UNKNOWN</i>	LAST <i>UNKNOWN</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>147 26 1921</i>	17. INFORMANT <i>Mrs. Ronnie Rucker 412 Allendale St</i>	ADDRESS <i>ADDRESS</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) DUE TO, OR AS A CONSEQUENCE OF <i>respiratory failure</i>			1 day				
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (this hospital) attended the deceased from <i>June 27 1984</i> to <i>June 29 1984</i> , that (I) (we) last saw the deceased alive on <i>June 29 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <i>Joseph M. Reilly MD</i>			DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>6/29/84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH M. Reilly</i>			22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (TYPE IF Y)	23b. DATE <i>7-2-84</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Balt. Cem.</i>	23d. LOCATION CITY OR TOWN <i>Baltimore</i>	COUNTY <i>Md.</i>	STATE		
24. FUNERAL DIRECTOR NAME <i>Joseph L. Russ</i>	ADDRESS <i>2229 W. North Ave.</i>	25a. DATE REC'D. BY REGISTRAR <i>JUL 3 1984</i>	25b. REGISTRAR'S SIGNATURE <i>Randall</i>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by Item 18 above, injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										4 6 0 8				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR		
Ethel				Watford	June 19, 1984							10:38 ^a		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		Black		MONTH	DAY	YEAR	50				MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3958 Oxford Ave. 21215						
14. FATHER'S NAME FIRST James		MIDDLE	LAST Hoggard	15. MOTHER'S MAIDEN NAME FIRST Ellen		MIDDLE	LAST Sykes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-34-6483		17. INFORMANT David Green		ADDRESS 3958 Oxford Avenue								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension HCVD.</u> DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Not SEE Body.</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Clinic</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>84</u> , to <u>4/29</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Fortune Williams</u>		22c. DEGREE MD.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>20 June 84</u>								
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Fortune Williams</u>		22g. ADDRESS <u>4432 Park Heights.</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/25/84		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.		23d. LOCATION CITY OR TOWN Anne Arundel Co., Md.								
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 21 1984		25b. REGISTRAR'S SIGNATURE <u>Julie Davidson</u>								

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2003-3-29 15:00

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification in Item 20 must be checked.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 349-969

16409

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Garland			R.	Watson		June	5	1984	6:15 AM		
3. SEX			4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male			white	MONTH	DAY	YEAR	59	YRS.	6:15 AM		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
USA/Maryland			USA				Baltimore City, MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore			Wyman Park Health System, Inc.		unemployed		(disability)				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland			Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3533 Greenmount Ave 21218		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS		LAST	
George					Watson	Margaret		Richard Watson 8 Forest Street Glen Burnie		Rosenbaum 21061	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes			WWII		218-18-1687						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			5713		CANDROPULMONY Arrest						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)		SEPSIS (Sepsis)		respiratory distress syndrome				
{			(c)		Severe alcoholic liver Disease and acute v						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH OR EITHER: INJURY MEDICAL EXAMINERY		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21a PART 1 OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
21g. I certify that (I) (the hospital) attended the deceased from 6/14 1984 to 6/15 1984, that (I) (the hospital) saw the deceased alive on 6/14 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
21h. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS						6/17/84			
Dan Hellen Schenck, M.D.		DAN Hellen Schenck, M.D. Wyman Park Health System, Baltimore, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		6/8/84		Md. Vet. Cem. Garrison		Garrison Forest Balto. Co. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Burgee Funeral Home, 3631 Falls Road 21211				JUN 8 1984		John Davidson Pendleton					

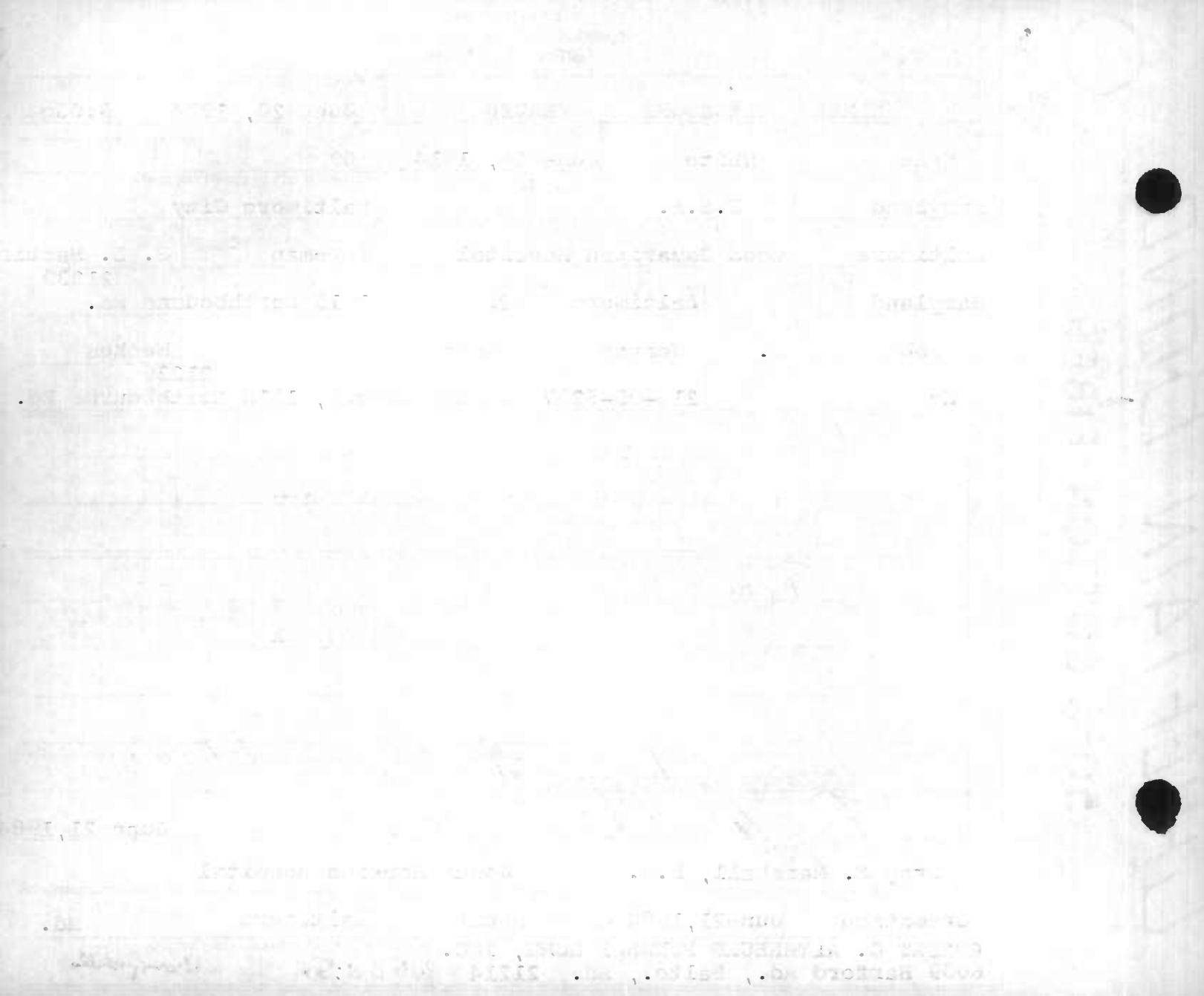


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	4	1	6	4	1	0
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
ELMER GLADSTONE WEAVER						June 20, 1984						3:05p m						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
Male			White			June 24, 1914			69									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.						Baltimore City									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore			Good Samaritan Hospital			Foreman			G. L. Martin									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21239					
Maryland					Baltimore					1915 Northbourne Rd.								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	Meckes						
John			R.		Weaver				Marie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21239						
No			216-03-5277			Annette Weaver, 1915 Northbourne Rd.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, hyperkalemia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Invasive Bacter corinoma</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c) _____																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Aortic valve</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
-			-			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>6/15/84</u> to <u>6/19/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Fray F. Marshall, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			June 21, 1984						
22d. PHYSICIAN'S NAME (IF DIFFERENT) <u>Fray F. Marshall, M.D.</u>			22e. ADDRESS			Johns Hopkins Hospital												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>			23b. DATE <u>June 21, 1984</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Green Mount</u>			23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Md.</u> STATE <u>Md.</u>									
24. ROBES & SHROUDS NAME <u>ROBERT C. ALtenburg</u> ADDRESS <u>FUNERAL HOME, INC.</u> 6009 Harford Rd., Balto., Md. 21214			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>JUN 22 1984</u> <u>The Davidson-Kendall</u>												



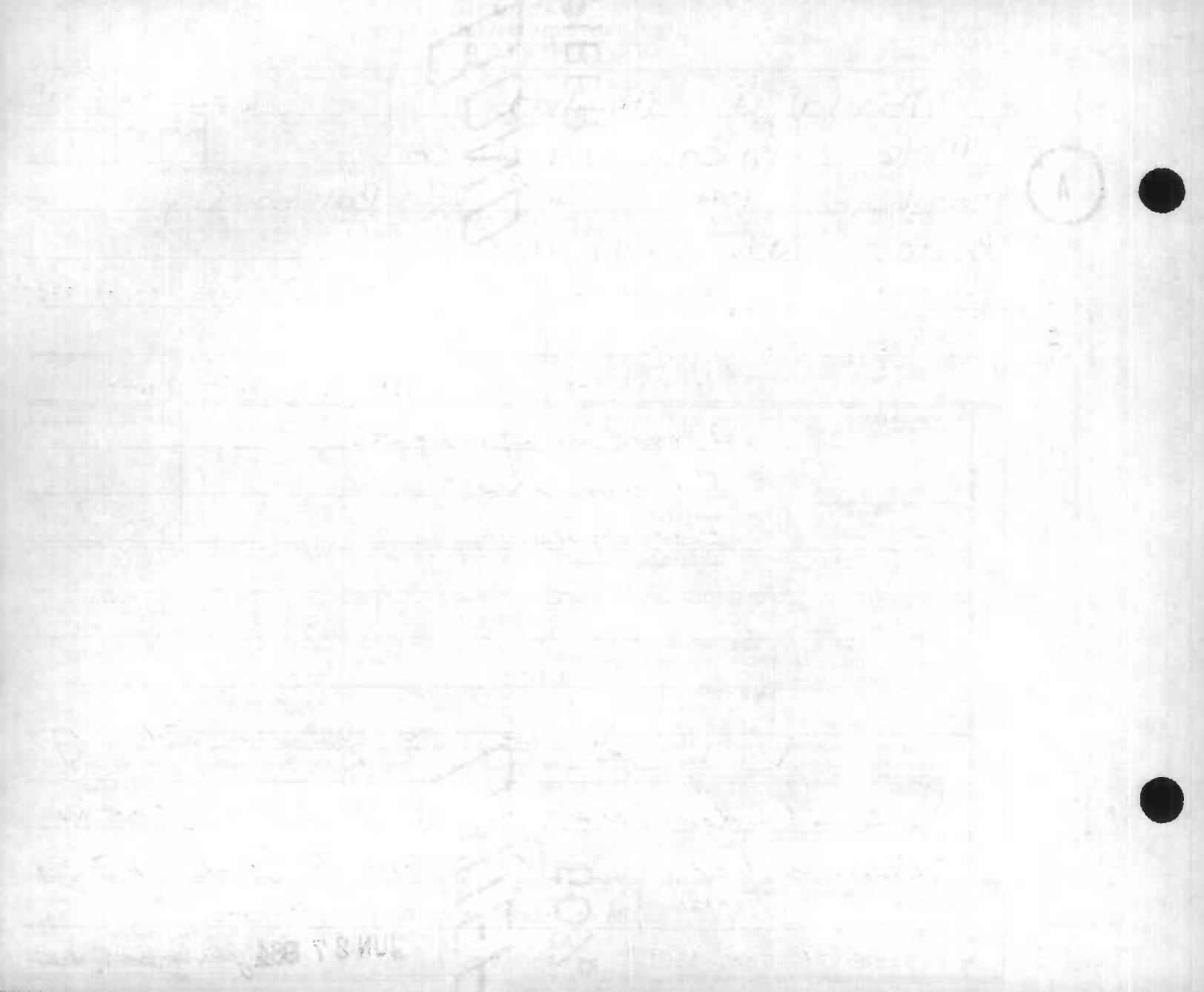
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

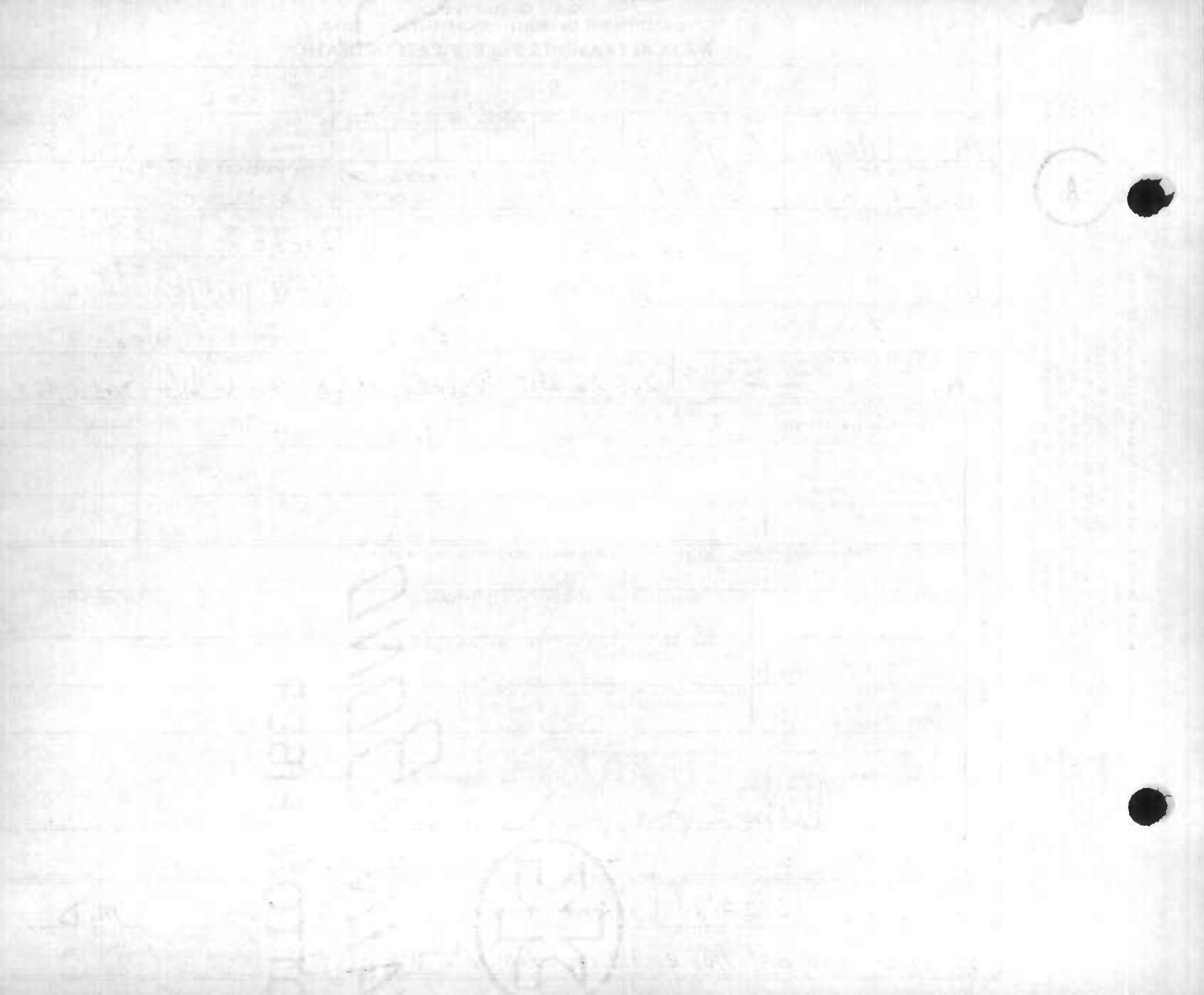
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 6 4 1					
1. DECEASED NAME (TYPE OR PRINT)				FIRST Harold J.	MIDDLE James	LAST Webb	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR				
				(Donald J.) (Hunters)				6 - 22 - 84				5:35 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		Black		09 02 08				75				YRS			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH John L. Deacon Med Center		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 112 S. Kossuth Street 21229							
13c. CITY OR TOWN Baltimore		15. MOTHER'S MAIDEN NAME Ruth				FIRST		MIDDLE		LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 108-14-8017		17. INFORMANT Mary Webb 112 S. Kossuth Street				ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxic encephalopathy</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac arrest</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypoxemia</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <i>June 15 1984</i> to <i>June 22 1984</i> , that (I) (we) lost sow the deceased alive on <i>June 22 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>John W. Reed</i>										22c. DEGREE DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John W. Reed</i>										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <i>6/25/84</i>					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/30/84		23c. NAME OF CEMETERY OR CREMATORIAL East Middletown Cem				23d. LOCATION CITY OR TOWN Middletown, COUNTY Pa.							
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc, 1101 E North Ave.										25a. DATE RECEIVED BY REGISTRAR JUN 27 1984					
										25b. REGISTRAR'S SIGNATURE <i>Johanna Henderson Pendall</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16412		
1- STATE REGISTRAR			1 DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
(TYPE OR PRINT)			James Webb						<input checked="" type="checkbox"/> MONTH DAY YEAR			6 18 19 84		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
m		NEGRO		8 18 28 55				MONTHS		DAYS HOURS MIN.		6 18 19 84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
N.C.			U.S.A.									Baltimore City		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			1129 N. Milton Street						Labor			#21205		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
MD.						BALTO.						1129 N. Milton Ave		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST		
?									EFFIE			Webb		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			245-26-6317			Robert Webb			3606 Warbach Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			Margarita A. Korell, M.D.			TITLE (SPECIFY) Assistant			DATE SIGNED 6/18/84					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6/23/84			23c. NAME OF CEMETERY OR CREMATORIAL Arbatus Mem. P.C.			23d. LOCATION CITY OR TOWN Arbatus			COUNTY STATE m.d.		
24. FUNERAL DIRECTOR NAME BETTS Funeral Home			ADDRESS 1129 N. Carolina St.			25a. DATE REC'D. BY REGISTRAR JUN 20 1984			25b. REGISTRAR'S SIGNATURE Julie Lundergan					
BP														
DHMH - 17 (VR A15 ME (5))														
20M 4/B2														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 4 1 6 4 1 3		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			George Elbert Weber						June 14, 1984			9:30 PM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			Caucasian			June 12, 1933			51 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			USA						Baltimore City			Koppers Co.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			819 Washburn Avenue			Printer			Printer					
13a. STATE Maryland			13b. COUNTY ---			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 819 Washburn Avenue, 21225		
14. FATHER'S NAME FIRST George			MIDDLE Edward			LAST Weber			15. MOTHER'S MAIDEN NAME FIRST Mabel			LAST Deihl		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea			17. INFORMANT Jean Powell 622 Washburn Ave., Baltimore,			ADDRESS Md. 21225					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Unknown DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) this physician attended the deceased from 14-June-84 to 14-June-84, that (I) saw the deceased alive on above, (I) saw the body after death			14-June-84			and that in my opinion death occurred on the date and hour and from the causes stated			14-June-84					
22b. SIGNATURE Richard E. Fisher, MD.			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 15-June-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 4700 Pennington Ave., Balto., Md. 21226											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/18/1984			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Md. 21226					
24. FUNERAL DIRECTOR NAME McCully Funeral Homes			24b. ADDRESS 237 E. Patapsco Ave.,			25a. DATE REC'D. BY REGISTRAR JUN 20 1984			25b. COUNTY A. A. Co. Md.					

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Add. Info. FilmG593 7/30/84 STATE OF MARYLAND
 FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1 - STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 24 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOAN	MIDDLE B.	LAST WEIMAN	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 6-8-84	MONTH JUN	DAY 16	YEAR 84	2b. HOUR 2PM			
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH 5 YEAR 1952	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 32	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD 6-12-84	MONTH JUN	DAY 12	YEAR 84	2d. HOUR 2PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3410 Old York Rd. (rear)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baenaid				12b. KIND OF BUSINESS OR INDUSTRY Bar		
13a. STATE Md	13b. COUNTY Balto	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 9 B Westway North		21221					
14. FATHER'S NAME FIRST Richard		MIDDLE 	LAST Golding	15. MOTHER'S MAIDEN NAME FIRST Gladys		MIDDLE 	LAST Beech	9 B Westway North				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-54-378		17. INFORMANT M.R. James Weinan		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8682 IMMEDIATE CAUSE (a) Acute carbon monoxide intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o). 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6/ ? 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Inhalation of fumes from car								
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in a car		21f. LOCATION STREET 3410 Old York Rd., (rear)		CITY OR TOWN Balto., Md.	COUNTY 	STATE 				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Margarita Korell		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE 6-13-84						
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (TYPE) Cremation		23b. DATE 6-14-84		23c. NAME OF CEMETERY OR CREMATORY Secularity Process		23d. LOCATION CITY OR TOWN Balto.		COUNTY 	STATE Md			
24. FUNERAL DIRECTOR NAME Joseph N. Zavavino		ADDRESS 263 S. Cobbs St. 21224		25a. DATE REC'D. BY REGISTRAR JUN 18 1984		25b. REGISTRAR'S SIGNATURE Lea Davidson-Pandell						

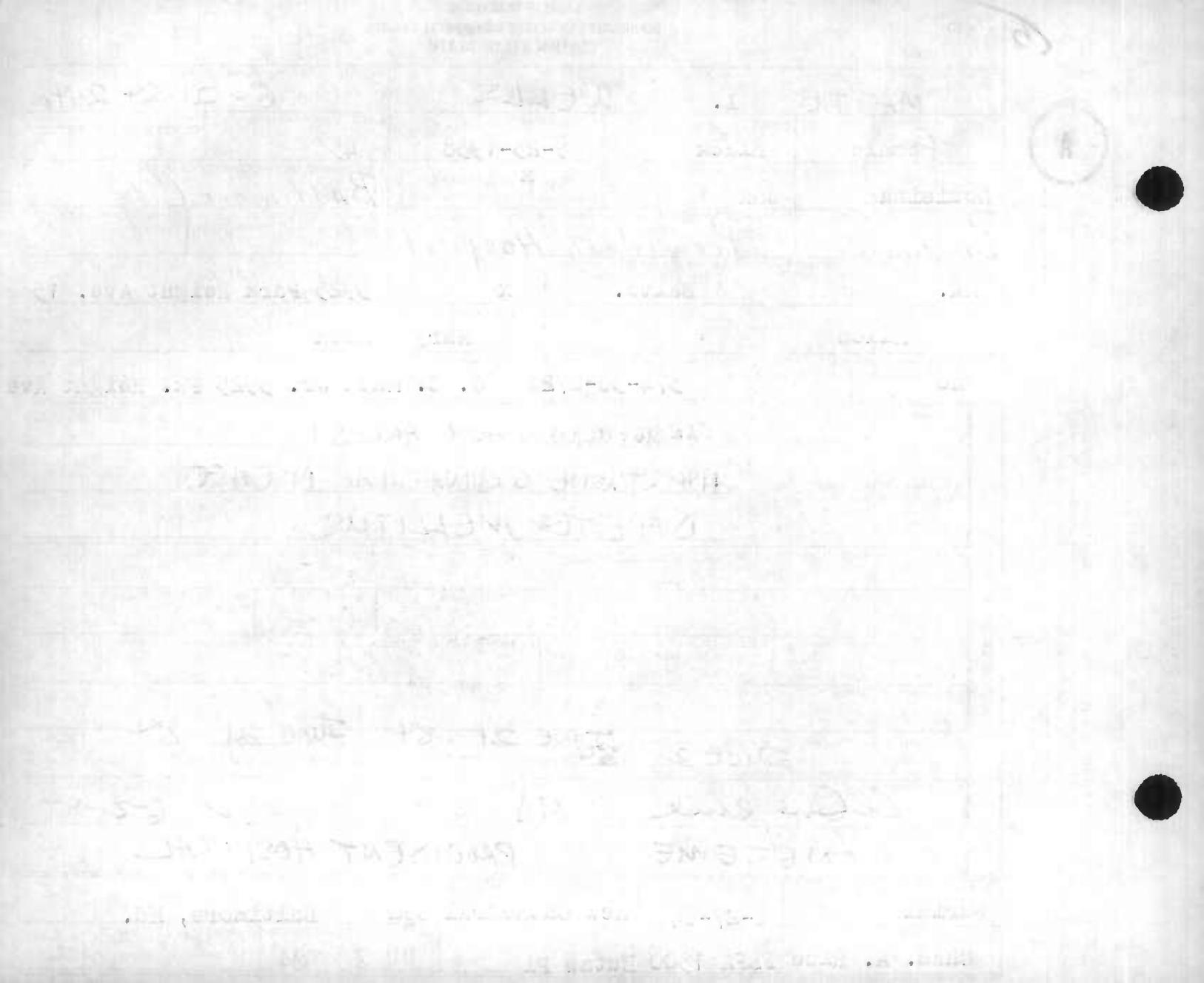
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 4 1 5	
												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
MATTIE I. WELLS									6 - 21 - 84			2-14pm	
3 SEX Female			4 RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 9-25-1938			6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			10a. CITY OR TOWN OF DEATH Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Providence Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS / ZIP CODE 3925 Park Height Ave. 15				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13b. COUNTY Balto.			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3925 Park Height Ave. 15				
14. FATHER'S NAME FIRST MIDDLE LAST Allen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mack			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 374-36-0728			17. INFORMANT ADDRESS J. C. Mack Jr. 3925 Pk. Height Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE													
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JUNE 21, 1984, to JUNE 21, 1984, that (I) (we) last saw the deceased alive on JUNE 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE C.Conejeme			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 6-21-84				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) C.Conejeme			22f. ADDRESS PROUDSENT HOSPITAL										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-27-84			23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem			23d. LOCATION CITY OR TOWN Baltimore, Md. COUNTY STATE				
24 FUNERAL DIRECTOR NAME Chas. A. Rice FSPA			ADDRESS 1300 Eutaw Pl			25a. DATE REC'D. BY REGISTRAR JUL 2 1984			25b. REGISTRAR'S SIGNATURE Julie Laidlow-Pandell				
DHMH - 16 50M 4/B3 (VRA 15, 4)													



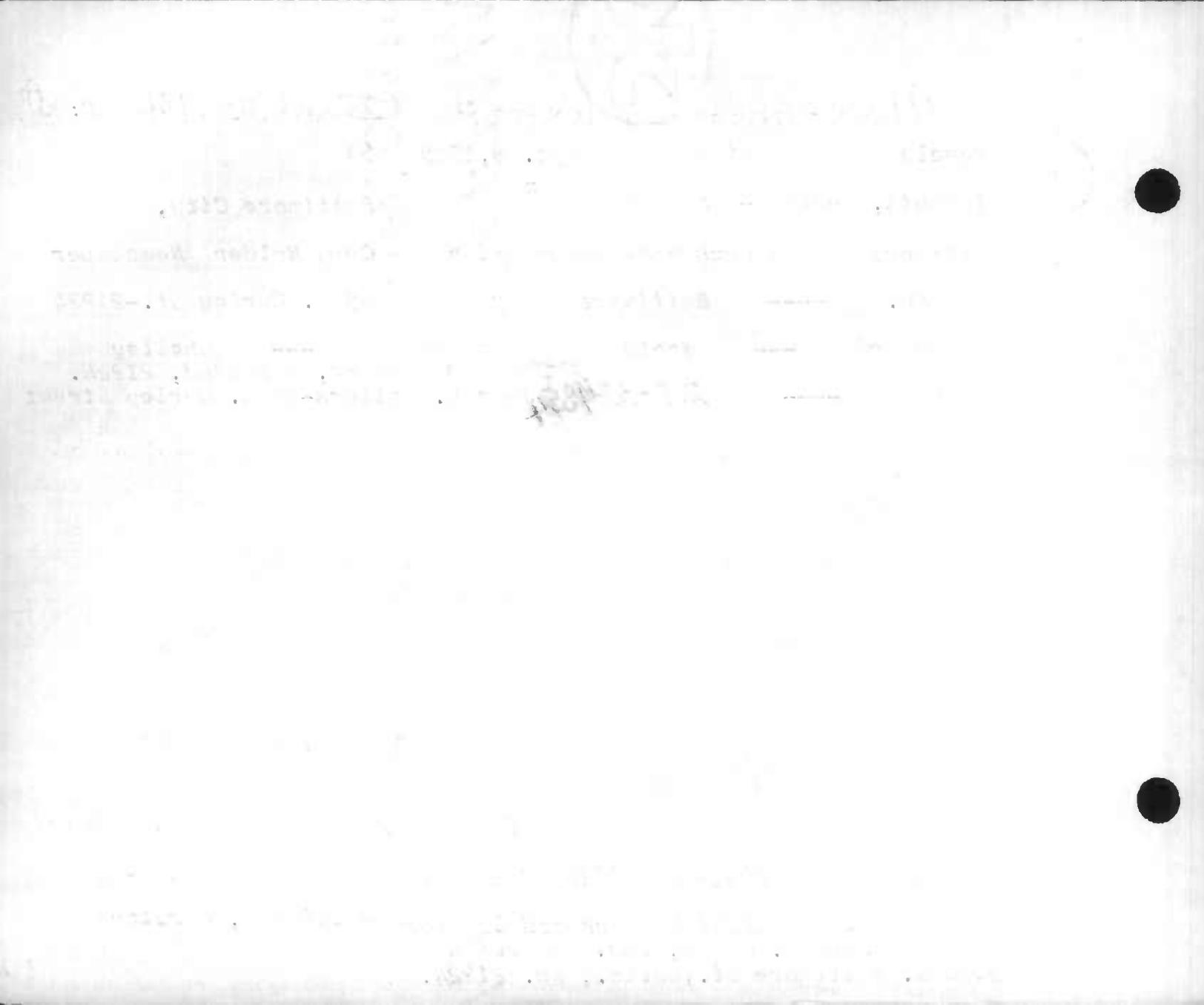
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 4 1 6 4 1 6											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>MARGARET D. Wetters</i>						<i>June 23, 1984</i>				2:00 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>Female</i>		<i>White</i>		<i>Sept. 8, 1925</i>		58		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Church Home Corporation</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Copy Holder</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Newspaper</i>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>---</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>25 N. Curley St.-21224</i>			
14. FATHER'S NAME <i>Edward</i>		MIDDLE <i>---</i>	LAST <i>Wooley</i>	15. MOTHER'S MAIDEN NAME <i>Dorothy</i>		MIDDLE <i>---</i>	LAST <i>Shelley</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY <i>213-32485</i>		16c. INFORMANT <i>John L. Wetters-25 N. Curley Street</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asthma attack</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>316</i>		21f. LOCATION STREET <i>95 Highland Ave</i> CITY OR TOWN <i>Baltimore</i> COUNTY <i>Maryland</i> STATE <i>MD.</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>3/16</i> to <i>6/23/84</i> , 1983, to 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>D.W. MacDONALD MD.</i>		DEGREE <i>MD.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/23/84</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D.W. MacDONALD MD.</i>		22e. ADDRESS <i>95 Highland Ave 21224</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/25/84</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cemetery</i>		23d. LOCATION STREET <i>95 Highland Ave</i> CITY OR TOWN <i>Baltimore</i> COUNTY <i>Maryland</i> STATE <i>MD.</i>					
24. FUNERAL DIRECTOR NAME <i>John A. Moran, Inc. Funeral Home</i> ADDRESS <i>3000 E. Baltimore St., Balto., Md. 21224</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 25 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John A. Moran, Inc. Funeral Home</i>							

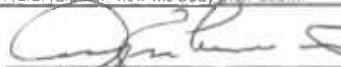


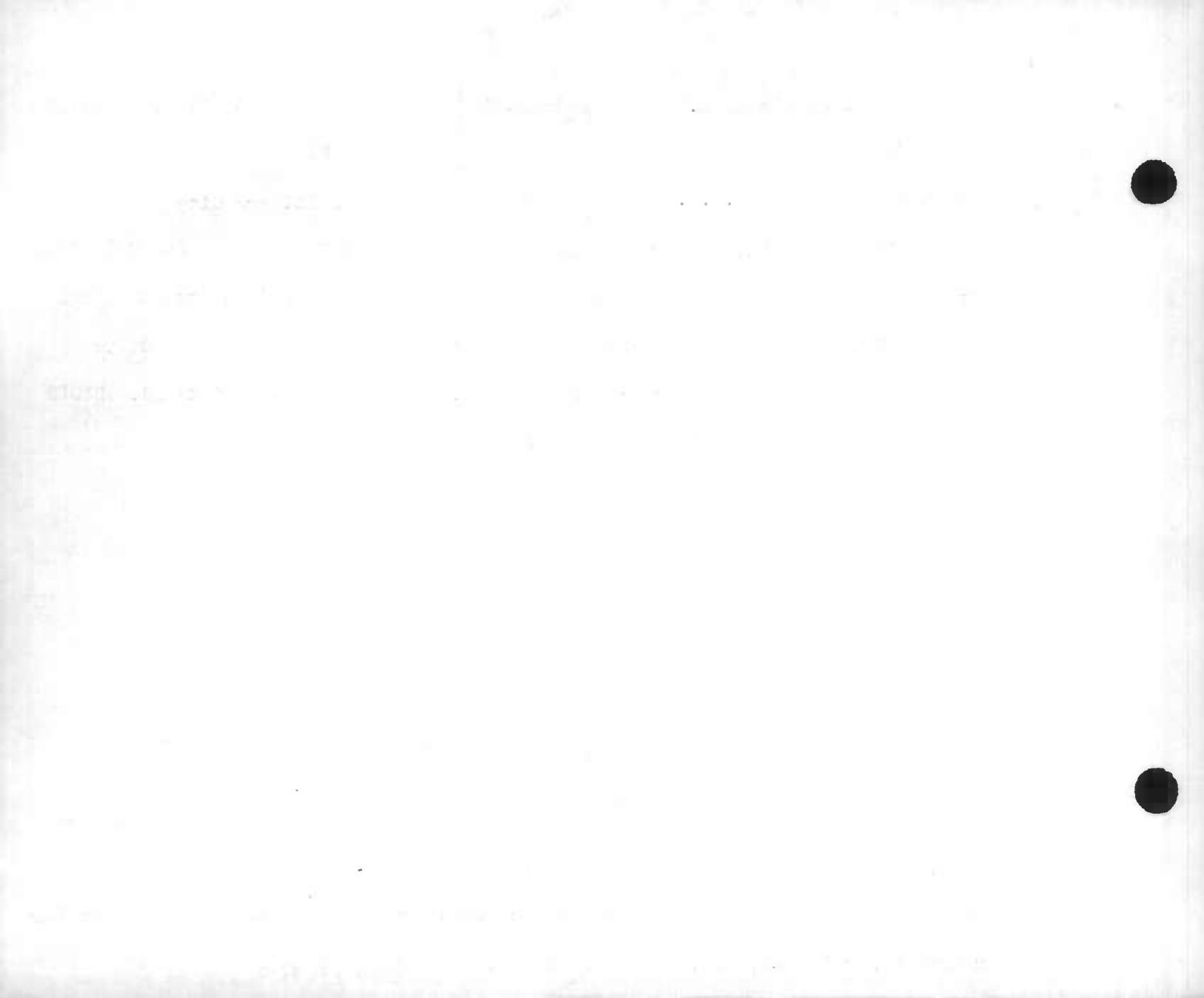
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if there shall have any injury, or other traumatic event, the medical examiner can be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 4 1 6 4 1 7
1. DECEASED NAME (TYPE OR PRINT) FLORENCE L. WHEATLEY			2a. DATE OF DEATH MONTH DAY YEAR 6 13 84	2b. HOUR 8:15P M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 5 15 03	6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7. BIRTHPLACE COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caton Manor Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3501 St. Paul Street 21202	
14. FATHER'S NAME FIRST William	MIDDLE	LAST Laynor	15. MOTHER'S MAIDEN NAME FIRST Anna	MIDDLE May	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 219-32-5372	17. INFORMANT Ogle H. Wheatley	ADDRESS 862 Magavista Rd. 21012		
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, Part 2, and Part 3) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1/2					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			
21e. SIGNATURE 	21f. DEGREE 	21g. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kochman	22b. ADDRESS 10 Stonehenge Circle	22c. DATE SIGNED 6/14/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 6/15/84	23c. NAME OF CEMETERY OR CRÉMATORIUM Loudon Park Crematory	23d. LOCATION CITY OR TOWN Baltimore	STATE Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.	24b. ADDRESS 21229 4107 Wilkens Ave.	25a. DATE REC'D. BY REGISTRAR JUN 15 1984	25b. REGISTRAR'S SIGNATURE 		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use or the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 2 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) EDWARD			FIRST F	MIDDLE WHITE JR	LAST	6 21 84							1200 M	
3. SEX Male			4. RACE Black	5. DATE OF BIRTH MONTH 03 DAY 08 YEAR 94			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS 90 DAYS		IF UNDER 24 HRS HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA S.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Balt, Md			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF Md Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION CONSTRUCTION			12b. KIND OF BUSINESS OR INDUSTRY 21216					
13a. STATE MD			13b. COUNTY BALT.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4511 PROSPECT CIRCLE					
14. FATHER'S NAME FIRST EDWARD			MIDDLE F.	LAST WHITE	ST.	15. MOTHER'S MAIDEN NAME FIRST JULIA			MIDDLE	LAST WHITE	ADDRESS DAUGHTER 4511 PROSPECT CIR. BALT, MD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 231-09-6797			17. INFORMANT Amelia Miller			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) HEMOPHYYSIS											
			(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Steven A. Henry			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/21/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven A. Henry MD			22e. ADDRESS 4511 PROSPECT CIRCLE,											
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 6/27/84			23c. NAME OF CEMETERY OR CREMATORIAL King Memorial Pk.			23d. LOCATION Randallstown, Md.					
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.			ADDRESS 1101 E North Ave.			25a. DATE REC'D. BY REGISTRAR JUN 25 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Yes" then item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

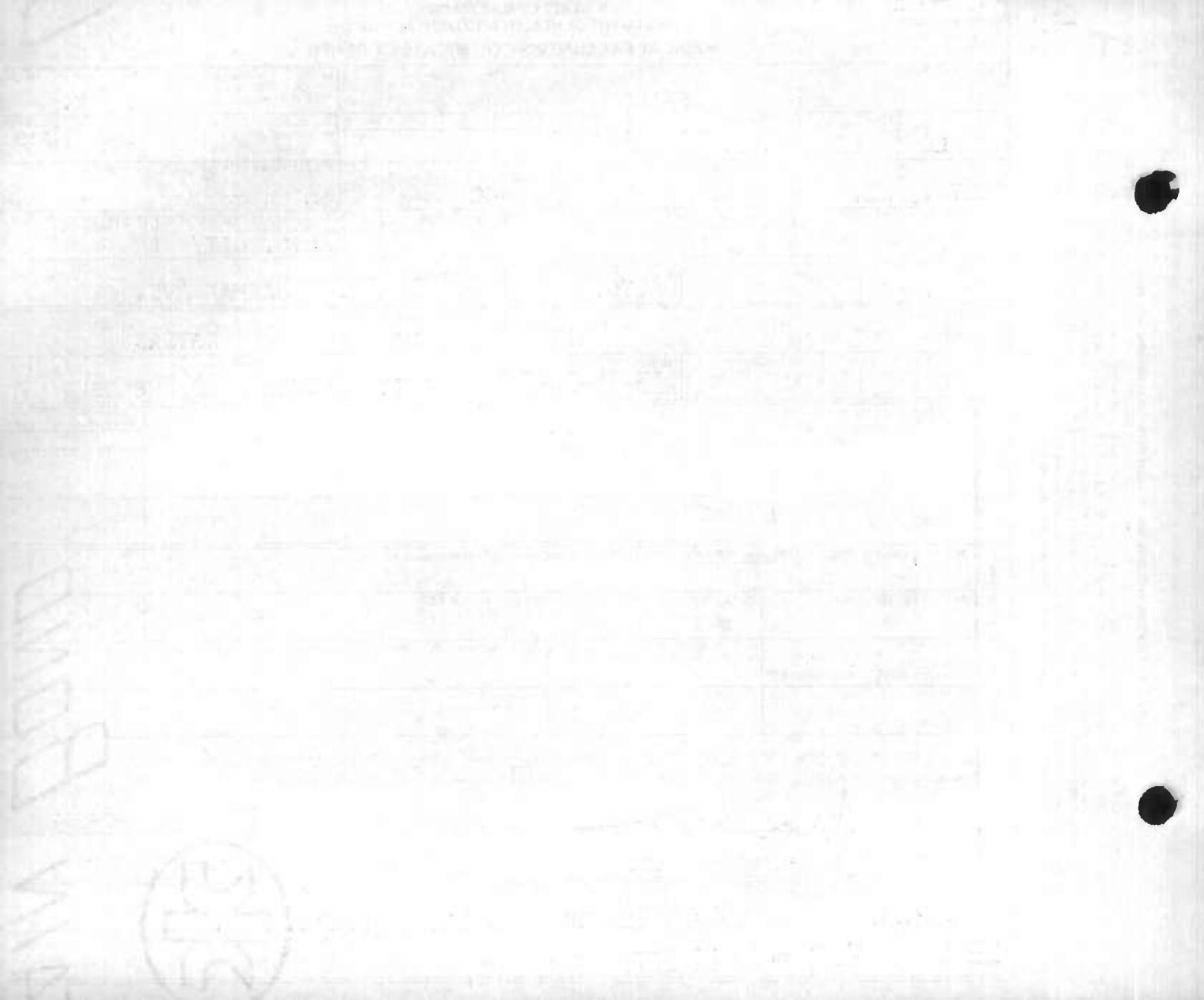
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	4	1	6	4	1	9		
										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
<i>Fannie</i>			<i>Mae</i>	<i>White</i>		<i>6/14/84</i>			<i>6/14/84</i>	<i>142</i>	<i>P.M.</i>							
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
Female			Black		MONTH	DAY	YEAR	76			YEARS	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
<i>Baltimore</i>			<i>U. S. A.</i>				<i>Baltimore City</i>											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
<i>Baltimore</i>			<i>Key Circle Nursing Home</i>		<i>Housewife</i>			<i>Home</i>										
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
<i>Maryland</i>					<i>Baltimore</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<i>2449 Woodbrook</i>								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST							
			<i>Unknown</i>			<i>Mary</i>					<i>Miller</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS										
(If Yes, give war or dates) <i>No.</i>			<i>212-03-9527</i>		<i>Doria Reese</i>			<i>3501 White Chapel Road</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <i>cardiac arrest</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
			<i>4280</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) <i>C-H-F. Atrial fibrillation.</i>															
			DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <i>2-17-84</i> to <i>6-14-84</i> ; that (I) (we) last saw the deceased alive on <i>5-31-84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Ashah</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. G. SHAH</i>			22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial			<i>6/19/1984</i>		<i>Mount Calvary Cemetery</i>		<i>Anne Arundel Co. Maryland</i>											
24. FUNERAL DIRECTOR <i>Nutter & Sons Funeral Home Inc.</i>			25a. ADDRESS <i>2501 Gwynns Falls Parkway Baltimore, Maryland 21216</i>		25b. DATE REC'D. BY REGISTRAR			25c. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>										
					<i>JUN 19 1984</i>													

十二、土壤

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3416420					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR	
		JOSEPH			ISAAC		WHITE				6	23	19	84	M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTH MONTHS DAYS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD	MONTH		DAY		2d. HOUR
MALE		BLACK		AUG. 15, 1914		69						6	23	19	84	6:37 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		BALTIMORE CITY		BALTIMORE CITY		MD.			
BALTO., Md.		USA															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Sinai Hospital		BALTO.		BALTO. CITY											
13a. STATE		13b. COUNTY		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. STREET ADDRESS		21215							
MD.				EDWARD F. WHITE		AMANDA WATERS		2920 BOARMAN AVE.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		21226									
NO		213-14-2893		BERNADETTE BOOKER		3418 SHELLSUN CT											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				<input type="checkbox"/>		YES <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		Ann M. Dixon, M.D.		TITLE (SPECIFY) Assistant M.D.		MEDICAL EXAMINER		DATE SIGNED		6-24-84							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6/27/84		23c. NAME OF CEMETERY OR CREMATORIAL ARBURUS MEM. Pk.		23d. LOCATION CITY OR TOWN BALTO., Md.		COUNTY		STATE							
24. FUNERAL DIRECTOR LEROY O. DYETT 4600 ADDRESS LIBERTY HGTS. AVE.						25a. DATE REC'D. BY REGISTRAR JUN 26 1984		25b. REGISTRAR'S SIGNATURE Leiron Randall									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified before the death certificate is signed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 16421			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
William RAY White						6/27/84			JUN 27 1984		3:10 P.M.		
3. SEX M			4. RACE W			5. DATE OF BIRTH			6. AGE (IN YEARS AT DEATH)			IF UNDER 1 YEAR	
						MONTH 10 DAY 10 YEAR 26			57			IF UNDER 24 MRS	
									YRS.			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SINAI Hosp. of BACP.			12a. USUAL OCCUPATION Manager			12b. KIND OF BUSINESS OR INDUSTRY Service Station				
13a. STATE MD			13b. COUNTY BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1722 Central Ave Glendale MD 21071				
14. FATHER'S NAME William Middle Last Lissie White			15. MOTHER'S MAIDEN NAME Estes A. Middle Mills Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 234-36-8628			17. INFORMANT Freida Waugh			ADDRESS 610 Hammettshire Rd Owings Mills, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.										(b) Acute MI v. Palm Gomelus			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Parkinson's Disease, Angina													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5105			21f. LOCATION STREET			CITY OR TOWN BALTIMORE COUNTY BALTIMORE STATE MD.				
22a. I certify that (I) (this hospital) attended the deceased from 6/27/84, 1984, to 6/27, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE						DEGREE			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			6/27/84				
Cremation			23b. DATE June 28, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Pk.			23d. LOCATION CITY OR TOWN BALTIMORE COUNTY BALTIMORE STATE MD.				
24. FUNERAL DIRECTOR NAME H.J. Edelhardt			ADDRESS Owings Mills, Md.			25a. DATE REC'D. BY REGISTRAR JUN 29 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton				

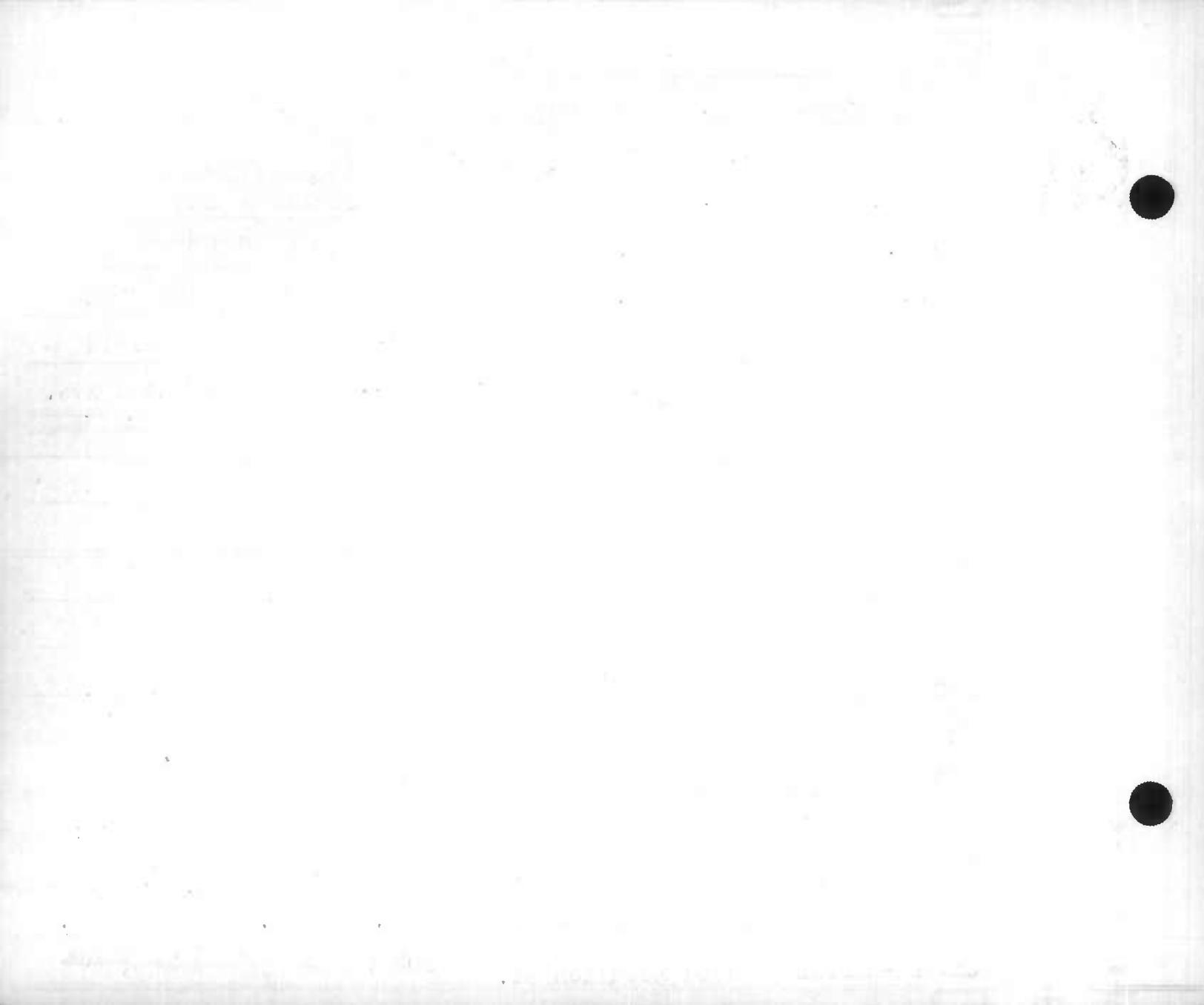
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 4 1 6 4 2 2					
						REG. NO.					
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Mattie I. Whiting						6	10	84			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		11 23 16		67		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Va.		USA				Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balto.		1002 Druid Hill Avenue				Waitress		21201			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13e. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS		13e. STREET ADDRESS			
Md.				Balto.		1002 Druid Hill Avenue		21201			
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			
Philip				Whiting	Henrietta			Martha Whiting 1002 Druid Hill Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			213-20-5115			Martha Whiting					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)						Carcinoma of Esophagus					
1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED (IN CERTIFYING CAUSES OF DEATH)?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.											
22b. SIGNATURE <i>Walter Correll MD</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. ADDRESS 1900 E NORTHERN PKWY		22e. DATE SIGNED 6/11/84					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6/14/84		23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.		23d. LOCATION CITY OR TOWN Balto.		COUNTY		STATE Md.	
24. FUNERAL DIRECTOR NAME Chatman-Harris FH 1701 McCulloh St.						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 13 1984 Julia Davidson-Kendall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign. Page 4 if page 3
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please enclose carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical certifying physician must sign this section.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 4 2 3					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Ronald I. Widdeskind				I.	Widdeskind	6			5	84	1910	M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Male			White			MONTH DAY YEAR			40 YRS.			MONTHS	DAYS	IF UNDER 24 HRS.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA									Baltimore City MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore			University of Maryland Shock Trauma contractor									BUILDING					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Maryland			BALTIMORE			Lwings Mill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12119 Park Heights Ave 21117					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
JAMES WIDDENKIND						Helen KOWALCZYK Sherman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES			1963-1969			212-44-8203			JACQUELINE S. JOHNSON			HURLOCK, MARYLAND			4 days.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Cerebral Hypoxia</u>																	
9530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <u>Self Hanging (Suicide Attempt</u>					
{ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
Name																	
9a. DATE OF OPERATION <u>None</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
2:52xx 6-1- 1984			Hanging														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
			Jail			Western District Police Station, Balto. City, Md.											
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1984</u> , to <u>June 5, 1984</u> , and that in (my) (our) opinion death occurred during this time and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>James W. Carter MD</u> <u>June 5/84</u>					
22b. SIGNATURE <u>James W. Carter MD</u>			22c. DEGREE <u>ATTENDING PHYSICIAN</u>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. ADDRESS <u>James W. Carter</u> <u>Shock Trauma</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-8-1984			23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory			23d. LOCATION CITY OR TOWN Hebron Wicomico Md.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME Marvel-Short Funeral Home Delmar, Del.			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 11 1984			25b. REGISTRAR'S SIGNATURE <u>Gloria Anderson-Harrell</u>								

• 17 •

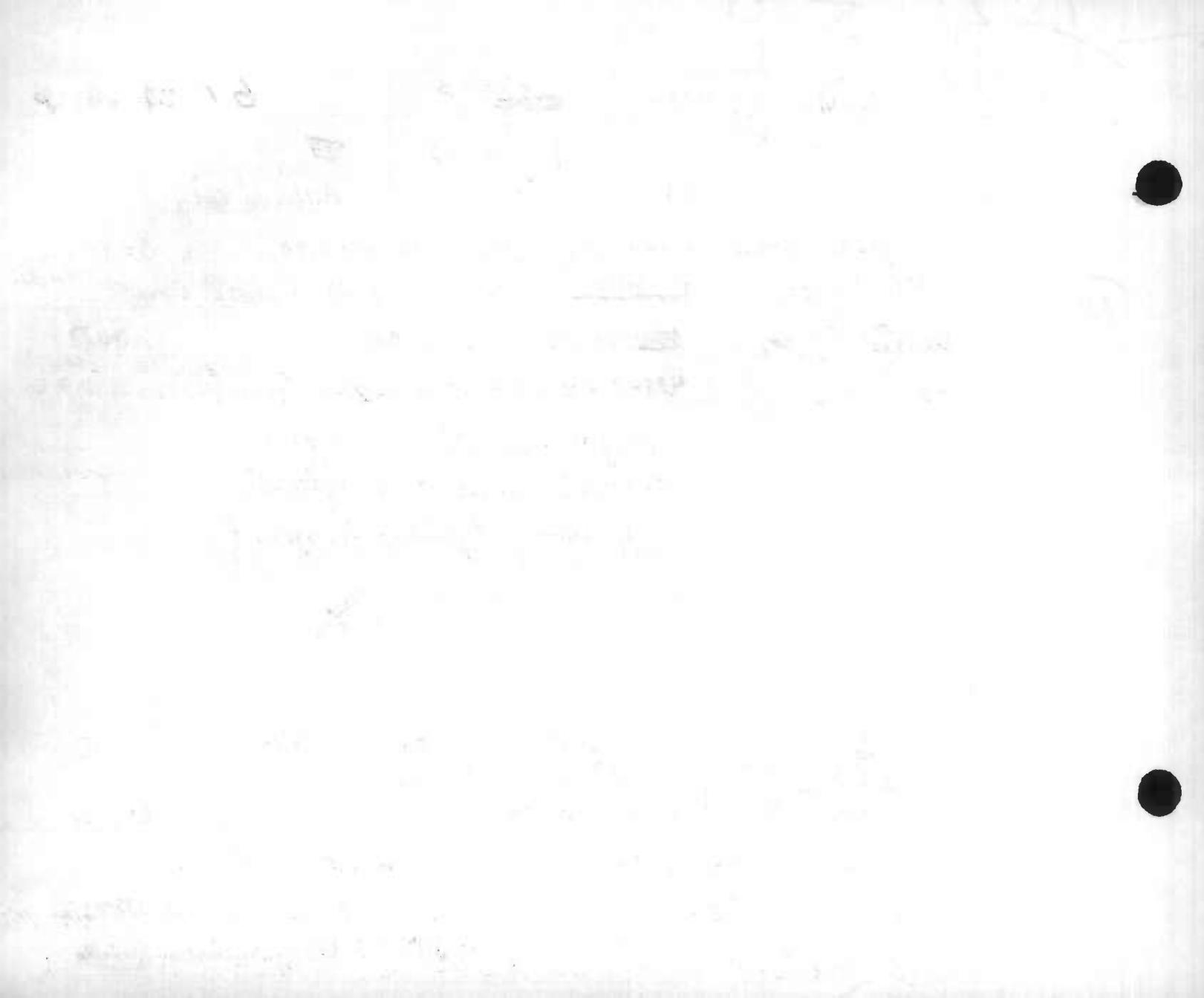
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 4 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 6 4 2 4								
										REG. NO.								
1 - STATE REGISTRAR		1 DECEASED NAME			FIRST	MIDDLE	LAST	WIEENS	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
		LYDIA MIRE							6 16 84					10:24 P.M.				
3. SEX		FEMALE		RACE	C.A.U.		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
							M 8 6 37		13 46 YRS.		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MISSISSIPPI		7b. CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
								WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City								
10. CITY OR TOWN OF DEATH		BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		GOOD SAMARITAN Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		CLERK		12b. KIND OF BUSINESS OR INDUSTRY RETAIL						
13a. STATE		Md		13b. COUNTY		BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21136						
14. FATHER'S NAME		FIRST	CADE	MIDDLE	LAST	CALCOTE		15. MOTHER'S MAIDEN NAME		LOUISE		ADDRESS 2 PEDIWELL Court						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		No		16b. SOCIAL SECURITY NO.		4286 80238		17. INFORMANT		DENNIS E. WIEENS		REISTERSTOWN, MD. 21130						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) Respiratory arrest - Septic																		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Recurrent breast cancer spread																		
DUE TO, OR AS A CONSEQUENCE OF (c) effusion, lymphangiitis, sepsis																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/16/84 to 6/16/84, that (I) (we) lost saw the deceased alive on 6/16/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.																		
22b. SIGNATURE James F. Knudsen M.D.										DEGREE	22c. DATE SIGNED 6/16/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James F. Knudsen										ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION										23b. DATE 6/18/84	23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW CEMETERY CRETATORIAL		23d. LOCATION CITY OR TOWN CATONSVILLE		COUNTY BALTIMORE		STATE MD.	
24. FUNERAL DIRECTOR NAME R. Gary Hettengale										ADDRESS OWINGS MILLS	25a. DATE REC'D. BY REGISTRAR JUN 19 1984		25b. REGISTRAR'S SIGNATURE John J. Kehoe					

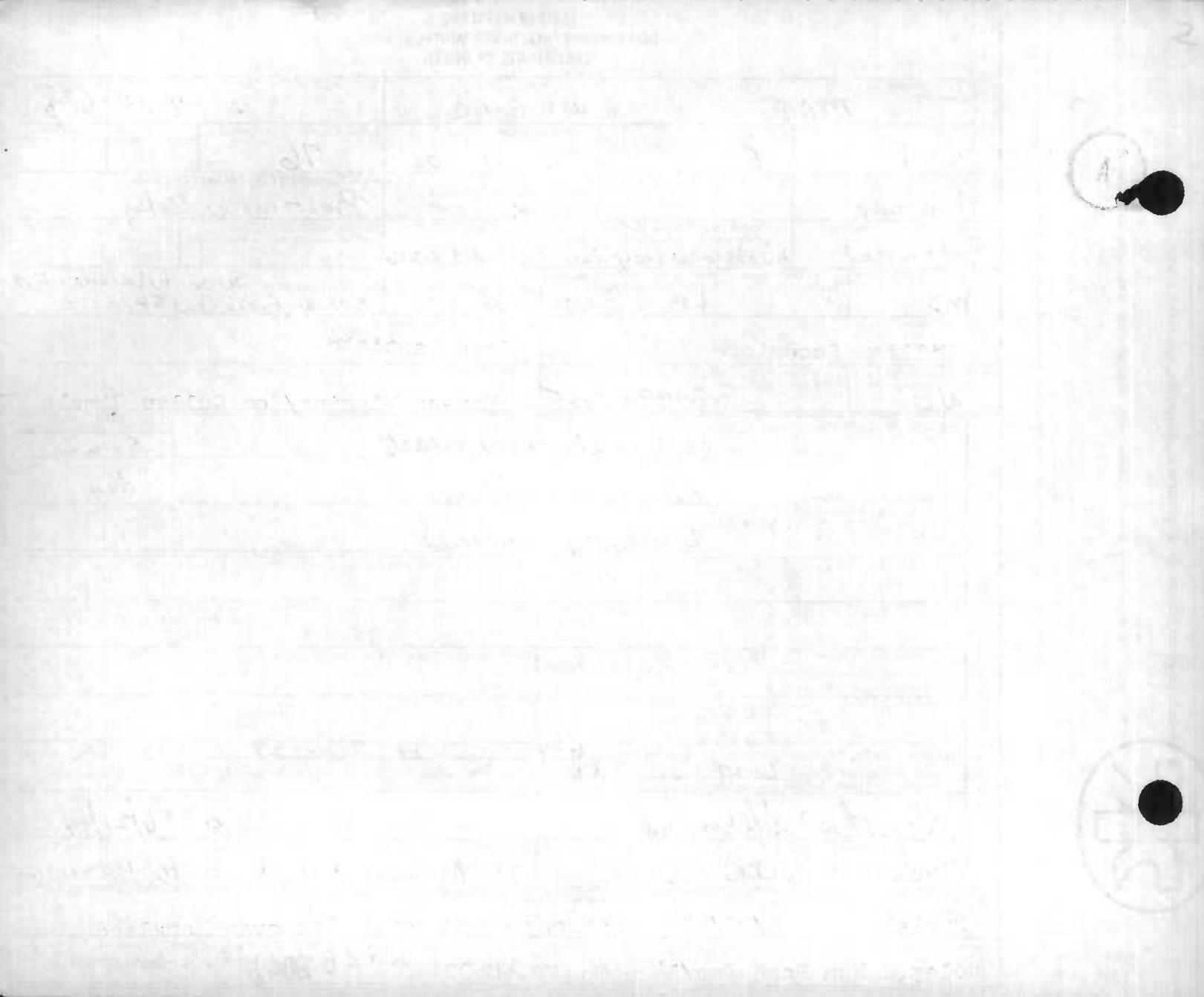


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 4	6 4 2 5				
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>MAE</i>	MIDDLE <i></i>	LAST <i>WIGGINS</i>	2a. DATE OF DEATH			MONTH JUN	DAY 28	YEAR 1984	2b. HOUR 6 27 84					
3. SEX <i>F</i>			4. RACE <i>B</i>		5. DATE OF BIRTH MONTH 5 DAY 11 YEAR 08			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>TRINIDAD</i>			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>			MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bethesda Hospital Balt Md 21216</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE <i>MD</i>			13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>Seton Hill Manor N. # 501 w. Franklin St. 21202</i>							
14. FATHER'S NAME FIRST <i>William</i>			MIDDLE <i>Goodridge</i>	LAST <i></i>	15. MOTHER'S MAIDEN NAME FIRST <i>Jone Baptiste</i>			MIDDLE <i></i>	LAST <i></i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>218887655</i>			17. INFORMANT			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Respiratory failure</i>)												days					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>recurrent pneumonia</i>)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>6-9</i> , 19 <i>84</i> , to <i>6-27</i> , 19 <i>84</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>6-27</i> , 19 <i>84</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) (we) did <input type="checkbox"/> (did not) view the body after death.																	
22b. SIGNATURE <i>Dorothy Stern MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <i>6/27/84</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DOROTHY STERN MD</i>			22e. ADDRESS <i>730 Ashburton Street Balt, Md 21216</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/30/84</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Harmony Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Landover Maryland</i>			23e. COUNTY <i></i>					
24. FUNERAL DIRECTOR NAME <i>Dudley, S Fun Home Inc/1425 Ma Ave, NE DC</i>			25a. DATE REC'D. <i>JUN 28 1984</i>			25b. BY REGISTRAR REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											



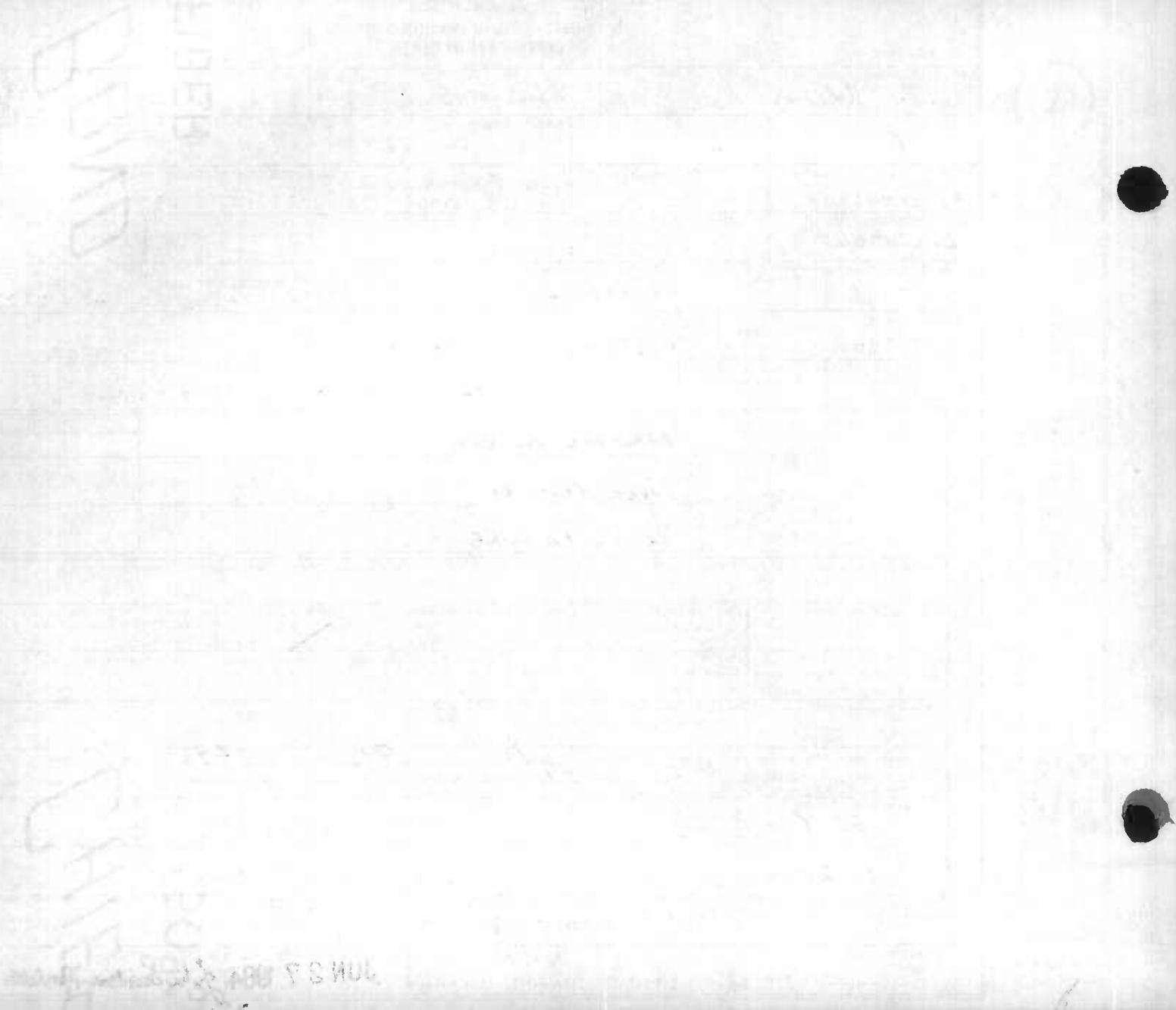
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8416426	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Annie</i>	MIDDLE <i>Mae</i>	LAST <i>WILLIAMS</i>	2a DATE OF DEATH	MONTH 6	DAY 24	YEAR 84	2b HOUR 12 ⁴⁸ A.M.	
3. SEX <i>F</i>		4. RACE <i>B</i>	5. DATE OF BIRTH MONTH 4			DAY 27	YEAR 45	6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY, MD.</i>			
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>PROVIDENT HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore,</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>2420 Etting Street 21217</i>			
14. FATHER'S NAME FIRST <i>Julius</i>			MIDDLE <i>Williams</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Thelma</i>			MIDDLE	LAST <i>Hunter</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unknown</i>		16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT		ADDRESS <i>Lindburg Williams 2417 Lauretta Avenue</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAL ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>LIVER FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>RENAL FAILURE</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/24</i> , 19 <i>84</i> , to <i>6/24</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>6/24</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W. Royal, M.D.</i>		22c. DEGREE				22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. Royal, M.D.</i>		22f. ADDRESS <i>2600 LIBERTY HEIGHTS</i>									
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>6/29/84</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Mount Zion Cem.</i>		23d. LOCATION CITY OR TOWN <i>Lansdowne,</i>		COUNTY		STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Wm C March F/H Inc.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 27 1984</i>				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>					
ADDRESS <i>1101 E North Avenue</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from this or the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 16b shows any injury, or other traumatic event, the medical examiner must be notified at once.

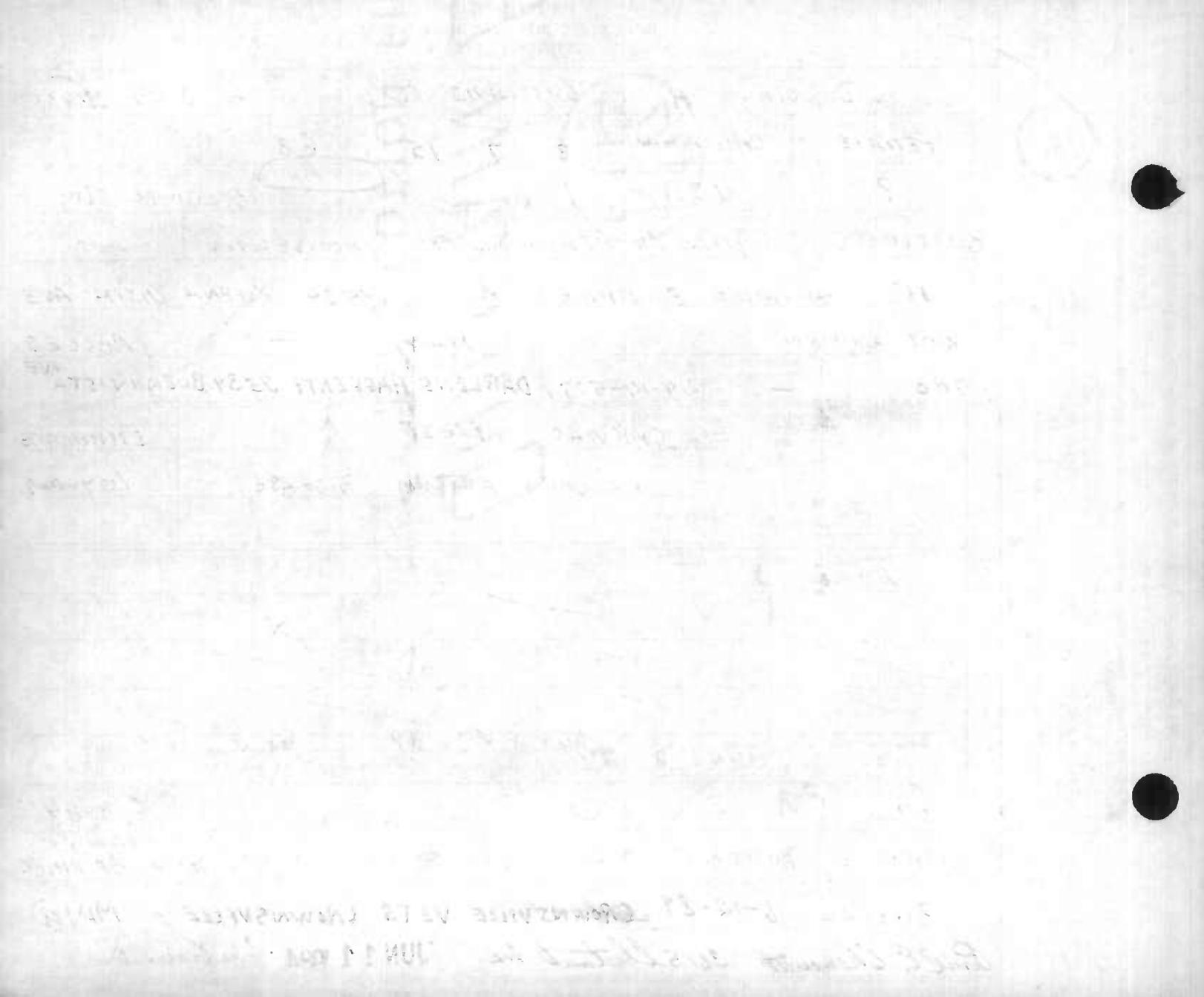
MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8416427

1. DECEASED NAME (TYPE OR PRINT)			FIRST DOROTHY	MIDDLE H.	LAST WILLIAMS	2a. DATE OF DEATH MONTH 6	DAY 8	YEAR 84	2b. HOUR 11:43 PM					
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH 8			DAY 7	YEAR 15	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ?			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WYMAN PK HEALTH SYSTEM			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY -					
13a. STATE MD			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3524 BUENA VISTA AVE						
14. FATHER'S NAME FIRST NOT KNOWN			MIDDLE —	LAST —	15. MOTHER'S MAIDEN NAME FIRST MARY			MIDDLE —	LAST ROLLES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-14-5774			17. INFORMANT IMMEDIATE CAUSE (a) CARDIAC ARREST			ADDRESS DARLENE HAGGERTY 3534 BUENA VISTA AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140			DOUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE			DOUE TO, OR AS A CONSEQUENCE OF (c) -			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 10 years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a NONE														
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) THE INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART I OR PART 2) —			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —			21e. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JUNE 8 , 19 84 , to JUN 8 , 19 84 , that (I) (we) last saw the deceased alive on JUNE 8 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (or did not) view the body after death.														
22b. SIGNATURE Cedric E. Dumont			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/8/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CEDRIC E. DUMONT			22e. ADDRESS 3100 WYMAN PK			23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VETS			23d. LOCATION STREET CITY OR TOWN COUNTY STATE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-12-84			23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VETS			23d. LOCATION STREET CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Paul E. Ehrenhardt			24a. ADDRESS 365 Belmont Ave			24b. DATE REC'D. BY REGISTRAR JUN 11 1984			24c. REGISTRAR'S SIGNATURE Sue Richardson-Pandall					
BP _____														
DHMH - 16 50M 1/81 (VRA 15, 4)														

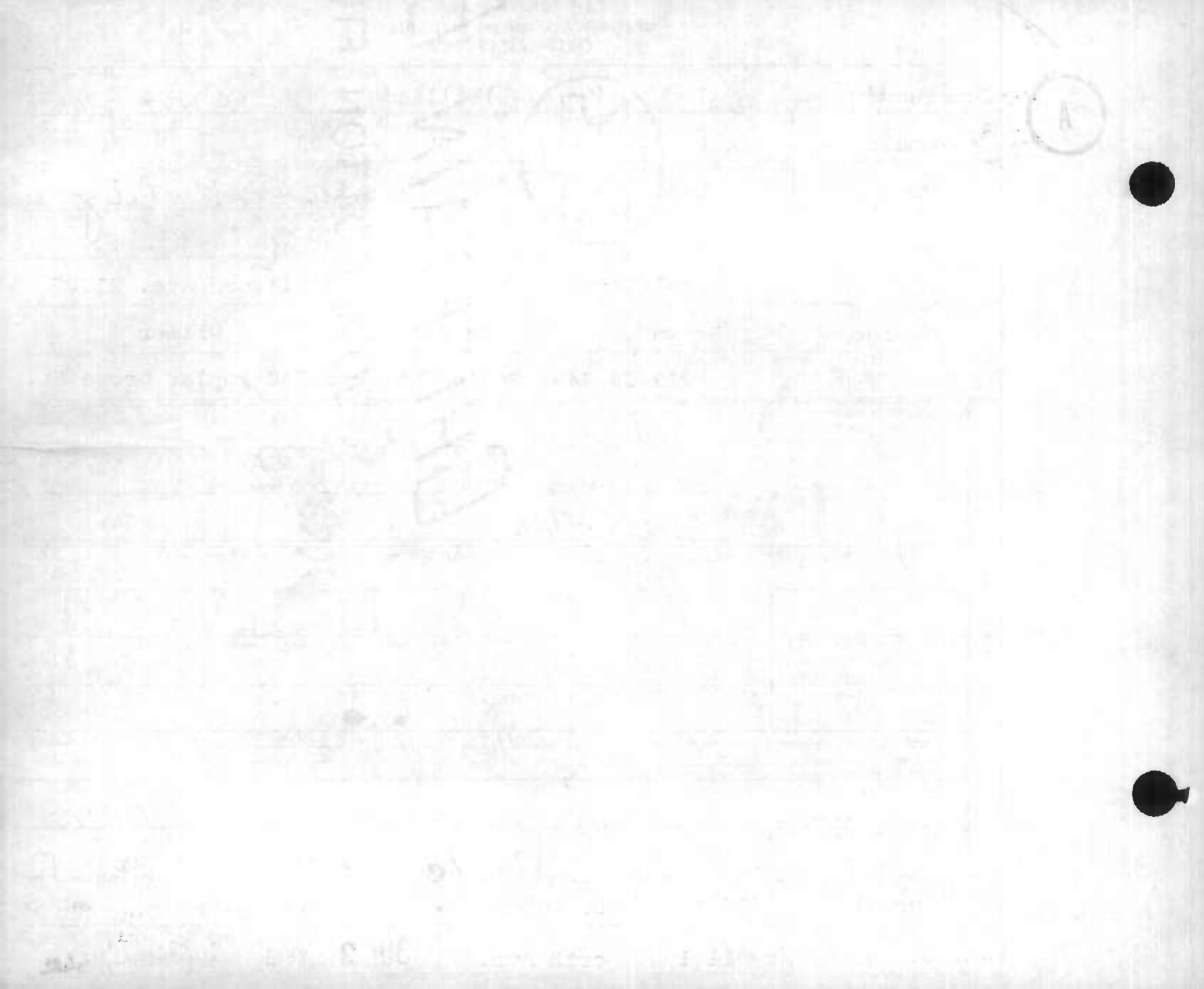


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8 4 1 6 4 2 8											
1 - FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Georganna (Georgeann) Williams			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR 6/29/84			2b HOUR 11:00 P.M.		
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 12 24 00			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		
7a. BIRTHPLACE COUNTRY MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD City		
10. CITY OR TOWN OF DEATH Baltimore MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hospital Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3623 Milford Ave. 21207		
14. FATHER'S NAME FIRST MIDDLE LAST George Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Wilmer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-28-0499			17. INFORMANT ADDRESS Sadie Matthews 740 Poplar Grove St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF. (c) Diabetes Mellitus											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from June 21 1984 to June 24 1984 , that (I) (we) last saw the deceased alive on June 21 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eugene Timmonson			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/29/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene Timmonson			22e. ADDRESS 2601 Liberty Street Ave. Baltimore MD 21205								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/3/84			23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.			23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE MD		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H			ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR JUL 2 1984			25b. REGISTRAR'S SIGNATURE Richard L. Johnson		



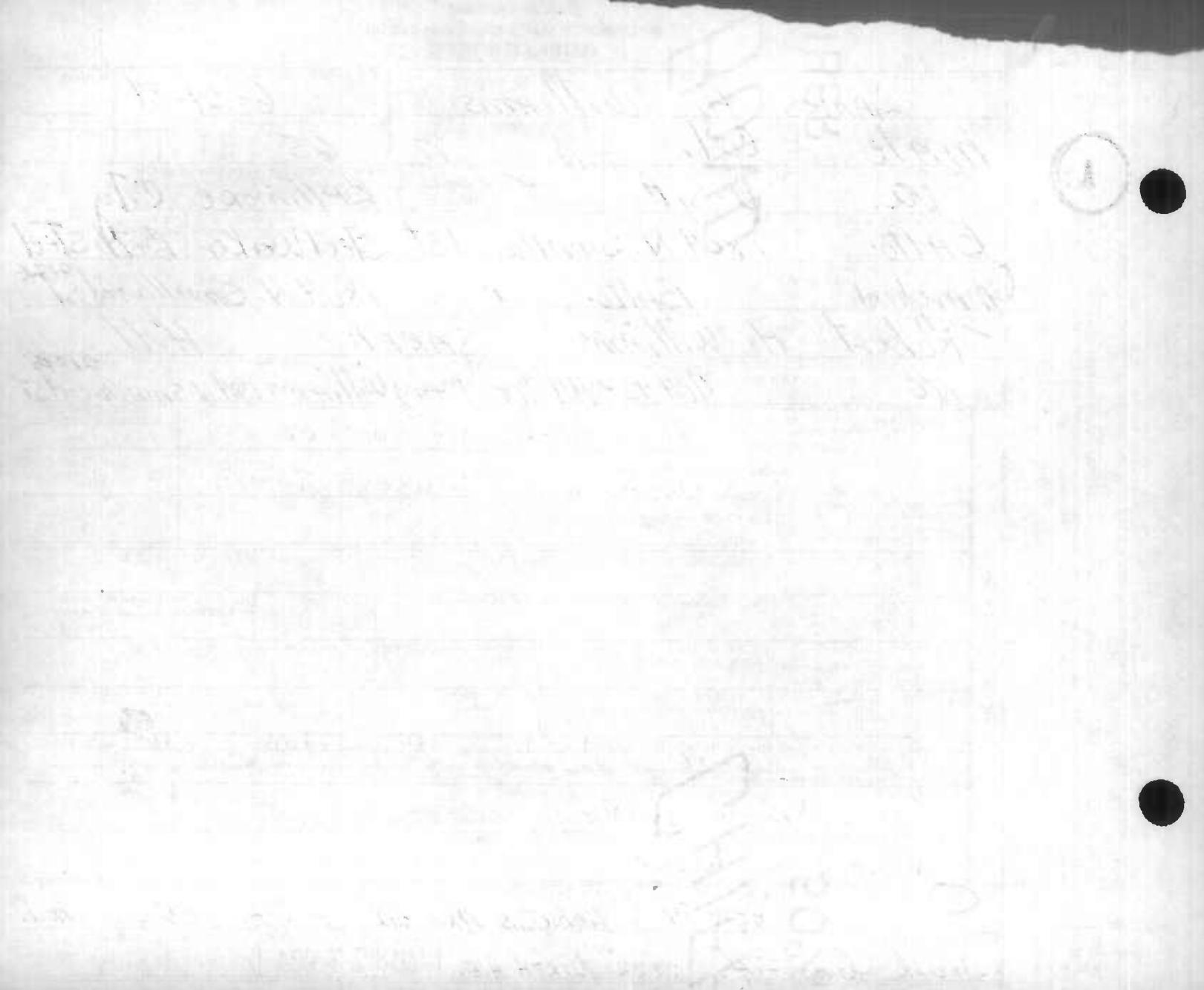
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 1 6 4 2 9							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
James H. Williams						6-29-84											
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
male		Col.		MONTH	DAY	YEAR	65			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Va.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Baltimore City			Steel Worker				Beth Steel			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
Baltimore		1804 N. Smallwood St										13a. STATE Maryland				13b. COUNTY Baltimore	
14. FATHER'S NAME		MIDDLE		15. MOTHER'S MAIDEN NAME			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1804 N. Smallwood St				ZIP CODE 21236			
Robert		H. Williams		Sarah			14. ADDRESS 1804 N. Smallwood St			14b. MIDDLE H. Williams				14c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21245			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. ADDRESS Mrs. Mary Williams 1804 N. Smallwood St							
NO				304-72-5964													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
DOUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC KIDNEY TUMOR																	
{ DOUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1-9 1984 to 6/16 1984, that (I) (we) lost sow the deceased alive on 6-16 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE SAVINDER K. JULKA			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAVINDER K. JULKA			22e. ADDRESS 107-109 E SERATOGA STREET.														
23a. CERIAL, CREMATION, REMOVAL REMOVED			23b. DATE 6-29-84			23c. NAME OF CEMETERY OR CREMATORIAL Aebutus Mem. Park			23d. LOCATION CITY OR TOWN Baltimore Co. Md.			23e. REGISTRAR'S SIGNATURE John Warden					
24. FUNERAL DIRECTOR NAME Joseph Auer 74			ADDRESS 2222 North Ave.			25a. DATE REC'D. BY REGISTRAR JUN 27 1984			25b. REGISTRAR'S SIGNATURE John Warden								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
8 4 16430											REG. NO.					
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)				MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			WILLIAMSON								JUNE 2, 1984				10:03PM	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White		MONTH DAY YEAR			83			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
W. Va.			U.S.A.						Baltimore City							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore			Church Home Hospital			Inspector			Clothing							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21213			
Md.					Baltimore					2910 Clifton Park Terrace						
14. FATHER'S NAME			FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME											
James			Harley Browning		Lina											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			233-14-8528A			Mrs. Genene Saxton,			3335 Kenyon Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiorespiratory Arrest													
4225																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)													
			(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Inability to Swallow																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
May 25, 1984			Inability To Swallow						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that <u>Bijpuria</u> attended the deceased from <u>MAY 25</u> , 19 <u>84</u> , to <u>JUNE 2</u> , 19 <u>84</u> , that he/she last saw the deceased alive on <u>JUNE 2</u> , 19 <u>84</u> , and that in my opinion death occurred on the date and hour and from the causes stated above. I have did not view the body after death.																
22b. SIGNATURE <u>M. L. Bijpuria</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED June, 2, 1984							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. L. Bijpuria			M.D.			22e. ADDRESS Church Hospital 100 North Broadway Baltimore, Md.			21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 6-5-84		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Nicholas T. Matthews, 3021 Eastern Avenue Baltimore, Md.						25a. DATE REC'D. BY REGISTRAR JUN 5 1984			25b. REGISTRAR'S SIGNATURE John Davidson Pendleton							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be telephoned for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 1 6 4 3 1						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
CECELIA T. WILSON							6/19/89									
3. SEX F			4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BART CITY MD.		MONTHS		DAYS HOURS MIN.					
10. CITY OR TOWN OF DEATH BART CITY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD			13b. COUNTY BART		13c. CITY OR TOWN BART		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE 838 Edmondson Ave. 21201							
14. FATHER'S NAME FIRST - MIDDLE - LAST -			15. MOTHER'S MAIDEN NAME FIRST - MIDDLE - LAST -													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown			16b. SOCIAL SECURITY NO. 220-30-3857		17. INFORMANT Elease Smith		ADDRESS 320 Gwynn Avenue									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
								<input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY (FROM ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)													
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18/89</u> to <u>6/19/89</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Mark Davis</u>										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/19/89		
22d. PHYSICIAN'S NAME, TYPE OR PRINT <u>Mark Davis</u>			22e. ADDRESS 907 BART MARYPIKE RD MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/22/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk. Arbutus,			23d. LOCATION CITY OR TOWN		COUNTY Md. 21043						
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc., 1101 E North Ave.										25a. DATE REC'D. BY REGISTRAR JUN 21 1984		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Pendleton</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

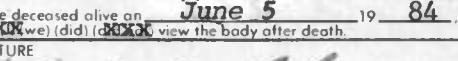
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 4 3 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST Mary	MIDDLE Lee	LAST Wilson	2a DATE OF DEATH MONTH DAY YEAR	2b. HOUR 4:50PM						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 20 1937		6. AGE (IN YEARS LAST BIRTHDAY) 46		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Baltimore City							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Baltimore, Maryland 21217		1620 W. North Ave			
14. FATHER'S NAME FIRST Curtis		MIDDLE	LAST Jenkins	15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE	LAST Williams	ADDRESS 1620 W. North Avenue Baltimore, Md. 21217				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 130-32-2779		17. INFORMANT Rev. Douglas Wilson									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 25 , 19 84 , to June 5 , 19 84 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 5 , 19 84 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.													
22b. SIGNATURE 		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/5/84			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Keith I. Adams, M.D.		22e. ADDRESS C/O Maryland General Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 6/11/1984		23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Memorial Park		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR Nutter & Sons Funeral Home Inc.		2501 Gwynns Falls Parkway ADDRESS Baltimore, Maryland 21216		25a. DATE REC'D. BY REGISTRAR JUN 8 1984		25b. REGISTRAR'S SIGNATURE Jane Darden-Kendall							

Designs International, Inc. 100,000 shares
of Preferred Stock, \$100 par value, Series A
Preferred Stock, issuable upon the conversion
of all or any portion of the outstanding
Debt Securities.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 4 3 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	2b. HOUR		
ROSALIE (nmi)					WILSON	JUNE 19, 1984	3:50 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS		2b. HOUR IF UNDER 24 HRS HOURS MIN.	
FEMALE		WHITE		1/9/1925		59 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE CITY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		CHURCH HOSPITAL, INC.				HOMEMAKER			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2958 SOLDERS POINT ROAD 21222	
14. FATHER'S NAME FIRST HARVEY		MIDDLE ROLLAND		LAST SHINDLECKER		15. MOTHER'S MAIDEN NAME GRACE		LAST ALLEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ARLENE BROWN		ADDRESS 6211 DANVILLE AVENUE BALTIMORE, MARYLAND 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RULE OUT ACUTE MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) ASCVD.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION JUNE 19, 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERIPHERAL VASCULAR DISEASE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) <input type="checkbox"/> this hospital attended the deceased from JUNE 15, 1984, to JUNE 19, 1984, that (I) <input type="checkbox"/> lost saw the deceased alive on JUNE 19, 1984, and that in (my) <input type="checkbox"/> own opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.									
22b. SIGNATURE K. GEORGE THOMAS		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/19/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. GEORGE THOMAS		22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MD.							
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/22/1984		23c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN CEMETERY		23d. LOCATION CITY OR TOWN BALTIMORE,		21231 COUNTY STATE MARYLAND	
24 FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222		25d. DATE REC'D. BY REGISTRAR 25e. REGISTRAR'S SIGNATURE ADDRESS JUN 21 1984 Julia Davidson-Pandelle							

4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3), it should be delivered to you at the burial permit. Then please remove carbon paper. Page 1 and 2 should be filled in by you with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WITNESS (if item 18 shows any injury or other traumatic event, this individual must be present)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
FELA						WIND MAN	6	2	84	11 A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
FEMALE		CAUCASIAN		8 18 21			62			YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE City MD.					
POLAND		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
BALTIMORE		Sinai Hospital								HOUSEWIFE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE						
MARYLAND				BALTIMORE					4228 LABYRINTH Rd. 21215						
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST			
UNKNOWN				HERSCHKOPF			UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO, NO OR UNKNOWN		16b. SOCIAL SECURITY NO. 220-84-5427		17. INFORMANT			ADDRESS								
							MRS. EDITH R. LANCER 6810 BROOKMILL RD. 21215								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2030 IMMEDIATE CAUSE (a)		Renal Failure - Azotemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Myeloma.													
		DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 4-28-1984 to 6-2-1987, that (I) (we) lost saw the deceased alive on 6-2-1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (and) did not view the body after death															
22b. SIGNATURE Rashbaum		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 6-2-84							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) RASHBAUM															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/3/84		23c. NAME OF CEMETERY OR CREMATORIAL RUDOMER VEREIN CEM			23d. LOCATION CITY OR TOWN ROSEDALE BALTIMORE MARYLAND		COUNTY MARYLAND		STATE				
24. FUNERAL DIRECTOR NAME 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215								25a. DATE REC'D. BY REGISTRAR JUN 6 1984		25b. REGISTRAR'S SIGNATURE Julie Levinson					

A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 4 1 6 4 3 5	
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR JUNE 18, 1984								2b. HOUR 1:30 p m	
1. DECEASED NAME (TYPE OR PRINT)		FIRST PAUL	MIDDLE E.	LAST WINGFIELD		5. DATE OF BIRTH MONTH DAY YEAR NOV. 6 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
3. SEX M		4. RACE B		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		12a. USUAL OCCUPATION LA-BORER		12b. KIND OF BUSINESS OR INDUSTRY BAKERY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE MD		13a. STATE md		13b. COUNTY BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE 1623 BAKE BURY GI			
14. FATHER'S NAME FIRST ROBERT MIDDLE WinsFIELD LAST		15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE Edwards LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 216 10 3401		17. INFORMANT IRENE WINGFIELD S/A		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Oat cell Ca of Lung with metastatic spread to bones, brain (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 29, 1984, to June 18, 1984, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 18, 1984, and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (XXX) view the body after death.													
22b. SIGNATURE H. Lann, M.D.		22c. DEGREE						22d. DATE SIGNED 6-18-84					
22e. ADDRESS 3900 Loch Raven Blvd. Balto Md 21218													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-22-84		23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest		23d. LOCATION CITY OR TOWN Reisterstown		23e. COUNTY Md.					
24. FUNERAL DIRECTOR NAME Brown - Thompson K.F.		ADDRESS 1913 W. Back St.		25a. DATE REC'D. BY REGISTRAR JUN 20 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 4 3 6

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Baby Boy		Winkley	06/08/84			1:05PM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		Black	MONTH	DAY	YEAR	MONTHS	YEARS	IF UNDER 24 HRS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
City								Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		The Johns Hopkins Hospital									
13a. STATE 13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD		Baltimore						1314 WIRTON 21202			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Gary			CORNISH	Catherine				WINKLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
(YES, NO OR UNKNOWN)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> 7651 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ 49 hrs											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (b + c) 19 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Intraventricular hemorrhage</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (s) (this hospital) attended the deceased from <u>June 10, 1984</u> to <u>July 8, 1984</u> , that (s) (we) last saw the deceased alive on <u>June 1, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Barbara Haber MD</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>6/18/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>Johns Hopkins Hospital</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			
								COUNTY	STATE		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
								<u>JUN 14 1984 John Davidson Pendee</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, or
imposed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shown any injury, an other trauma event, must be reported to the State Dept. of Health and Mental Hygiene.

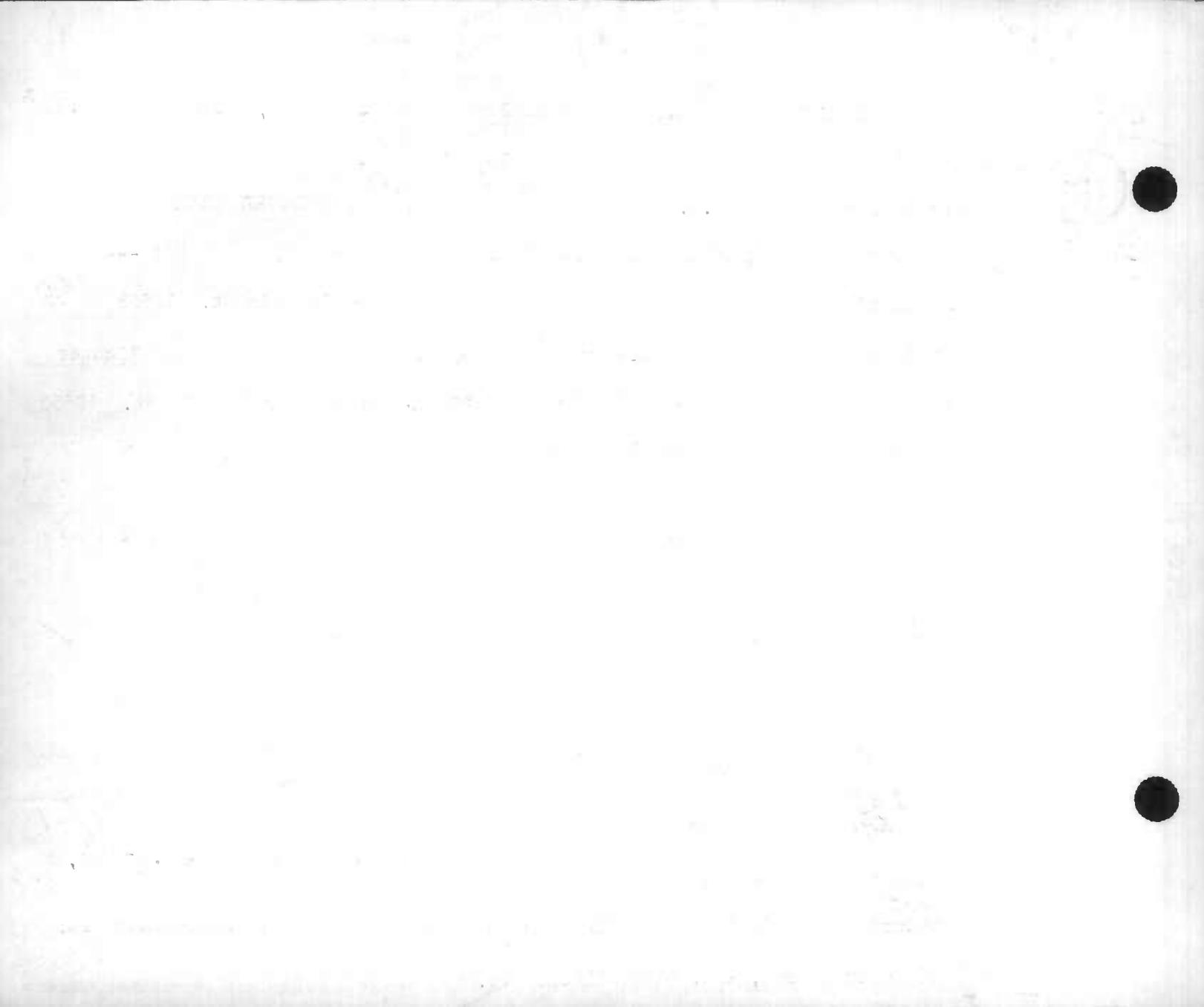


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled in with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																				
REG. NO.																				
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			DORIS			M			WINTERS			JUNE 10, 1984						8:51 A		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE [IN YEARS LAST BIRTHDAY]			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
Female			White			MONTH 5 DAY 20 YEAR 26			58			YRS.			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			MD.								
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wrapper			12b. KIND OF BUSINESS OR INDUSTRY Cigar Company											
13a. STATE Pennsylvania			13b. COUNTY			13c. CITY OR TOWN Ransom			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Box 14 Main St. 18653			99999					
14. FATHER'S NAME FIRST Walter			MIDDLE			LAST Huggler			15. MOTHER'S MAIDEN NAME FIRST Sophia			MIDDLE			LAST Richter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 209-18-0977			17. INFORMANT Lawrence R. Winters			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 0389 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>sepsis from empyema</u>			ADDRESS Box 14 Main St. 18653			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																				
19a. DATE OF OPERATION 2/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Idiopathic thrombocytopenia purpura</u>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/4</u> , 19 <u>84</u> , to <u>6/10</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6/10</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We will (did) not view the body after death.			22b. SIGNATURE <u>Eric A. Wiebre MD</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 6/10/84								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ERIC A. WIEBKE</u>			22f. ADDRESS 600 N. Wolfe Street, Balto, Md JOHNS HOPKINS HOSP. BALT MO 21205			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/13/84			23c. NAME OF CEMETERY OR CREMATORIAL Milwaukee Cemetery			23d. LOCATION CITY OR TOWN Milwaukee			COUNTY Lackawanna		STATE Pa.
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.			25a. DATE RECEIVED BY REGISTRAR 21229			25b. DATE REGISTRAR'S SIGNATURE JUN 11 1984														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4	6 4 3 8		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
BESSIE					WITKOWSKI	JUNE 29, 1984			IF UNDER 1 YEAR		IF UNDER 24 HRS		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE			WHITE		MONTH 2 DAY 29 YEAR 1888			96					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY		
POLAND			USA										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE			CHURCH HOSPITAL BROADWAY HOMEMAKER										
13a. STATE			13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21233		
Md					YES <input checked="" type="checkbox"/>			145 N. SLEEPER ST.					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
NO					CIARA LEWIS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			215-10-1329		CEREBROVASCULAR ACCIDENT								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT													
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from JUNE 25, 19 84, to JUNE 29, 19 84, that (I) (we) last saw the deceased alive on JUNE 29 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE A. F. Nazemi M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/29/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			CHURCH HOSPITAL							
ATAOULLAH F NAZEMI MD			100 N. BROADWAY BALTO. MD 21231										
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN				
BURIAL			7/03/84			STANISLAW CEM. BALTO			BALTO			Md	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Karczmarowski Funeral Home			2525 Fleet St.			JUL 2 - 1984			Julia Davidson-Randall				



20c GOVERNOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 inside.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

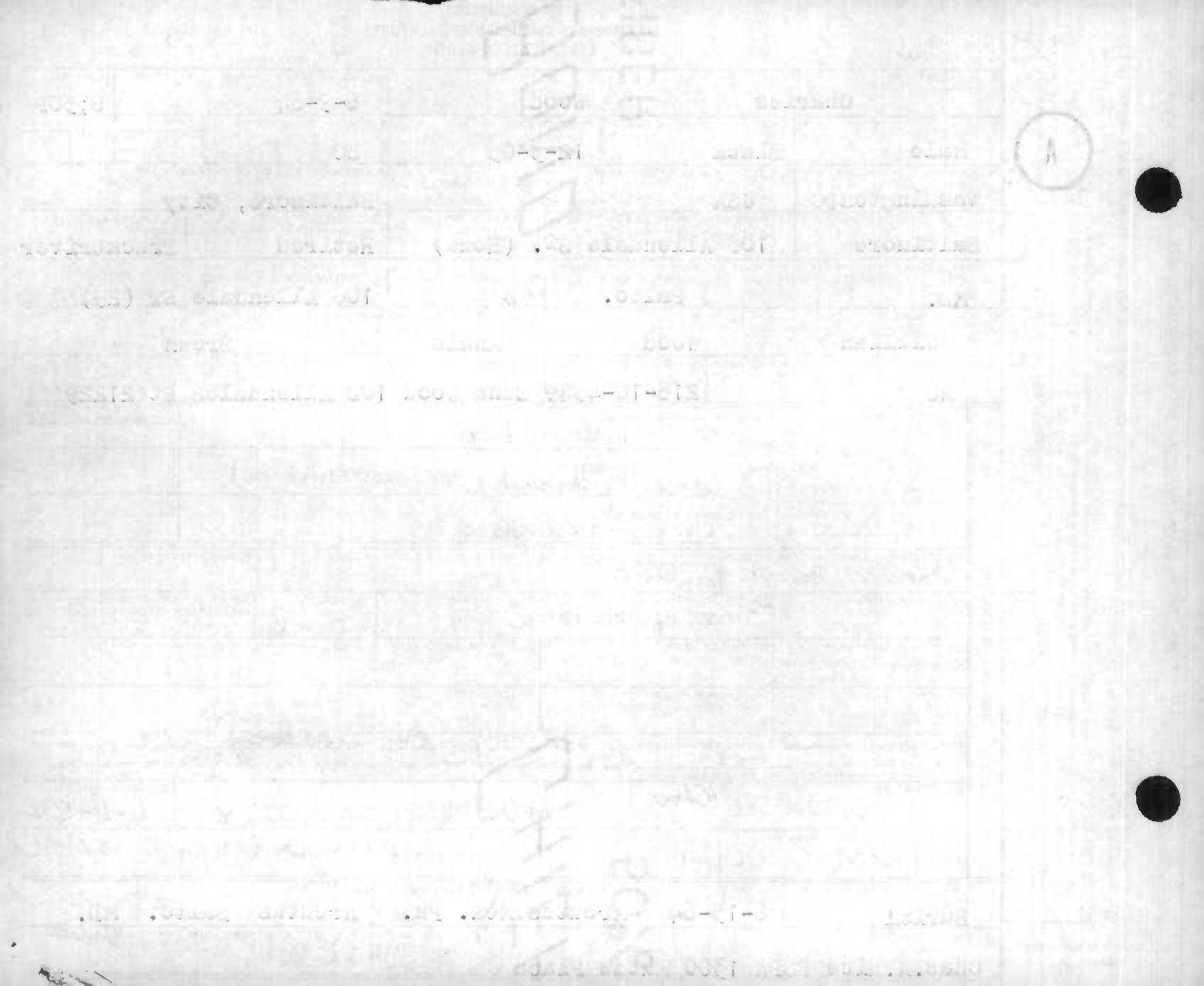
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be informed.

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 4 4 0
REG. NO.

1. DECEASED NAME [TYPE OR PRINT]			FIRST Charles	MIDDLE Wood	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 6:30PM				
3. SEX Male		4. RACE Black	5. DATE OF BIRTH MONTH 12 DAY 3 YEAR 03			6. AGE [IN YEARS LAST BIRTHDAY] 80 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0				
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City			MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 108 Allendale St. (Home)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Truck Driver				
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 Allendale St (29) 21229				
14. FATHER'S NAME FIRST William		MIDDLE Wood	LAST Wood	15. MOTHER'S MAIDEN NAME FIRST Annie		MIDDLE 	LAST Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-10-4949			17. INFORMANT Edna Wood 108 Allendale St 21229		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe malnutrition 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of stomach (adenocarcinoma) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Liver metastases												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Anemia, Heart failure												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of stomach			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 6-8-84		CITY OR TOWN 6-8-84			COUNTY 84	STATE MD.	
22a. I certify that (1) (the hospital) attended the deceased from 2nd May 1984 to 2nd May 1984 , that (1) (we) last saw the deceased alive on 6-8-1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) (did not) view the body after death.												
22b. SIGNATURE Francis Jel Oho		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED 6-11-84					
22d. PHYSICIAN'S NAME [TYPE OR PRINT] FRANCIS KHOO		22e. ADDRESS University of Maryland Cancer Center										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-15-84		23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN Arbutus			COUNTY Balto.	STATE MD.		
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Place		25a. DATE REC'D. BY REGISTRAR JUN 15 1984			25b. REGISTRAR'S SIGNATURE John D. Miller							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 4 1 6 4 4 1					
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
		Charles N. Wood						June 15, 1984						M	
3. SEX		4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Male		White			May 21, 1902			82							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Va.		U.S.A.						Baltimore City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore City		Long Green Nursing Home			Carpenter			Self-Employed							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		713 Argone Drive		21218					
14. FATHER'S NAME FIRST		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Charles Lewellen		Wood		Unknown		Fishpaw		No		215-07-6997		Joan Hendrickson		Towson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARCINOMA OF THE LUNG												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.		DO TO, OR AS A CONSEQUENCE OF (b)													
		DO TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 06-13-84 to 06-15-84, saw the deceased alive on 06-15-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														22c. DATE SIGNED 6/16/84	
22b. SIGNATURE Cesar G. Gamboa M.D.		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cesar G. Gamboa M.D.		22e. ADDRESS			3440 Belair Rd. Balto. Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Junel8, 1984			23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park			23d. LOCATION CITY OR TOWN Baltimore, Md.			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd. Balto. Md.														25. DATE REC'D. BY REGISTRAR/RECEIVED BY REGISTRAR'S SIGNATURE JUN 18 1984 John K. Johnson	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

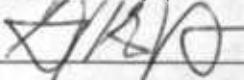
MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6442

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR	
Vincent					Woodard	6/16/84	T9				
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) YRS.	7 IF UNDER 1 YR. MONTHS	8 IF UNDER 24 HRS. DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR	
MALE	BLACK	7 2 63	20			6/16/84	T9			12:00	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD	
BALTO., Md.		USA					Baltimore City				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Baltimore		University Hospital								21201	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Md.				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		514 W. PRESTON ST.			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
EARNEST				WOODARD		ANNIE				CLAY	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO						ANNIE WOODARD 514 W. PRESTON ST.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to Left Shoulder</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY?				
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6/16/84		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f LOCATION STREET CITY OR TOWN 600 Block W. Preston St., Balto. City, Ma.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion							
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6/22/84		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN BALTO., Md.		COUNTY STATE Baltimore, Md.			
BP											
DHMH - 17 (VR A15 ME (5)) 20M 4/82											
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 6 JUN 19 1984		25b. REGISTRAR'S SIGNATURE 							
LEROY O. DYETT 4600 LIBERTY HGTS., AVE.											

rest & Law

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed and advised.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 4 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21b. HOUR	
HENRY T. WOODBURN						6-14-84				M	
3. SEX		M	4. RACE	W	5. DATE OF BIRTH MONTH DAY YEAR	8-18-1903	6. AGE (IN YEARS LAST BIRTHDAY)	80	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MARYLAND	7b. CITIZEN OF WHAT COUNTRY?		U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH		BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		2000 ODELL AVE.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			CHAUFFEUR	12b. KIND OF BUSINESS OR INDUSTRY	CASKET CO.
13a. STATE		MD.	13b. COUNTY		BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			21239	
14. FATHER'S NAME FIRST		JOHN	MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST	ALICE	MIDDLE	LAST	2000 ODELL AVE. APT. 1521	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		216-07-8868	17. INFORMANT	ADDRESS			21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease								5 minutes	
		DUE TO, OR AS A CONSEQUENCE OF (c)								15 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive Heart Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 19 85 to June 19 89, that (I) (we) last saw the deceased alive on June 4 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ADDRESS			4419 Falls Rd.			6/18/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE		
BURIAL		6-14-84	MEADOWRIDGE CEM.			BALTO., Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Marilyn Miller - 7527 Hanford Rd.					JUN 20 1984			Julia Davidson-Pendall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	4	1	6	4	4	
1. FOR STATE REGISTRAR		REG. NO.										8416444						
I. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES			MIDDLE M.	LAST WOODRUFF			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
3. SEX		4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male		White			MONTH 5			DAY 31		YEARS 1904		MONTHS 80		DAYS YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.								
Maryland		U.S.A.						Baltimore City		Electrical Construction								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. EMPLOYMENT (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Baltimore		Baltimore City Hospital						Construction		Beth. Steel								
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		13f. ADDRESS									
Maryland		Baltimore	Dundalk				218 Cleveland Avenue 21222											
14. FATHER'S NAME		FIRST Charles	MIDDLE	LAST Woodruff			15. MOTHER'S MAIDEN NAME		16. ADDRESS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
NO		213-07-9777			Lillian E. Woodruff		Same as 13e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio-respiratory arrest																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																		
(b) _____																		
{ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) Prior Syncope episodes with undetermined etiology																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Daniel M. Perlman MD MPH												22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED 6-28-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN Baltimore		23e. LOCATION CITY OR TOWN Baltimore		23f. COUNTY Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/1984			23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn		23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland									
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue Dundalk, MD. 21222			25a. DATE REC'D. BY REGISTRAR JUL 2 1984		25b. REGISTRAR'S SIGNATURE											

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Test 16. 1964

Its been a few days since we last

Weight Control Plan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if there was any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

#5,6, FilmG600 2/22/85 km

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 4 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Mr. Albert Ernest Woods Sr.						June 28, 1984				9:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Male		Caucasian		October 2 1921		61 62 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Illinois		USA				Baltimore City		Baltimore		North Charles General Hospital	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Maryland				Baltimore				8 S. Broadway St.		Retired	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		12b. KIND OF BUSINESS OR INDUSTRY	
Ray Woods						Florence (Unknown) Woods				Merchant Seaman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sharon Ralston		ADDRESS		21784		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no		085-18-7229		6601 Carroll Highlands		Eldersburg				Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis (Pseudomonas)</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>84</u> , to <u>6/28</u> , 19 <u>84</u> , that in (we) lost saw the deceased alive on <u>6/28</u> , 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Purnashottam Mitra</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/28/89					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Purnashottam Mitra</i>		22e. ADDRESS North Charles General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Creation		23b. DATE 6/29/84		23c. NAME OF CEMETERY OR CREMATORIAL Carroll Creation Ser.		23d. LOCATION CITY OR TOWN Hampstead		COUNTY		STATE Carroll Maryland	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133						25. DATE FILED IN REGISTRY JUL 3 1984					

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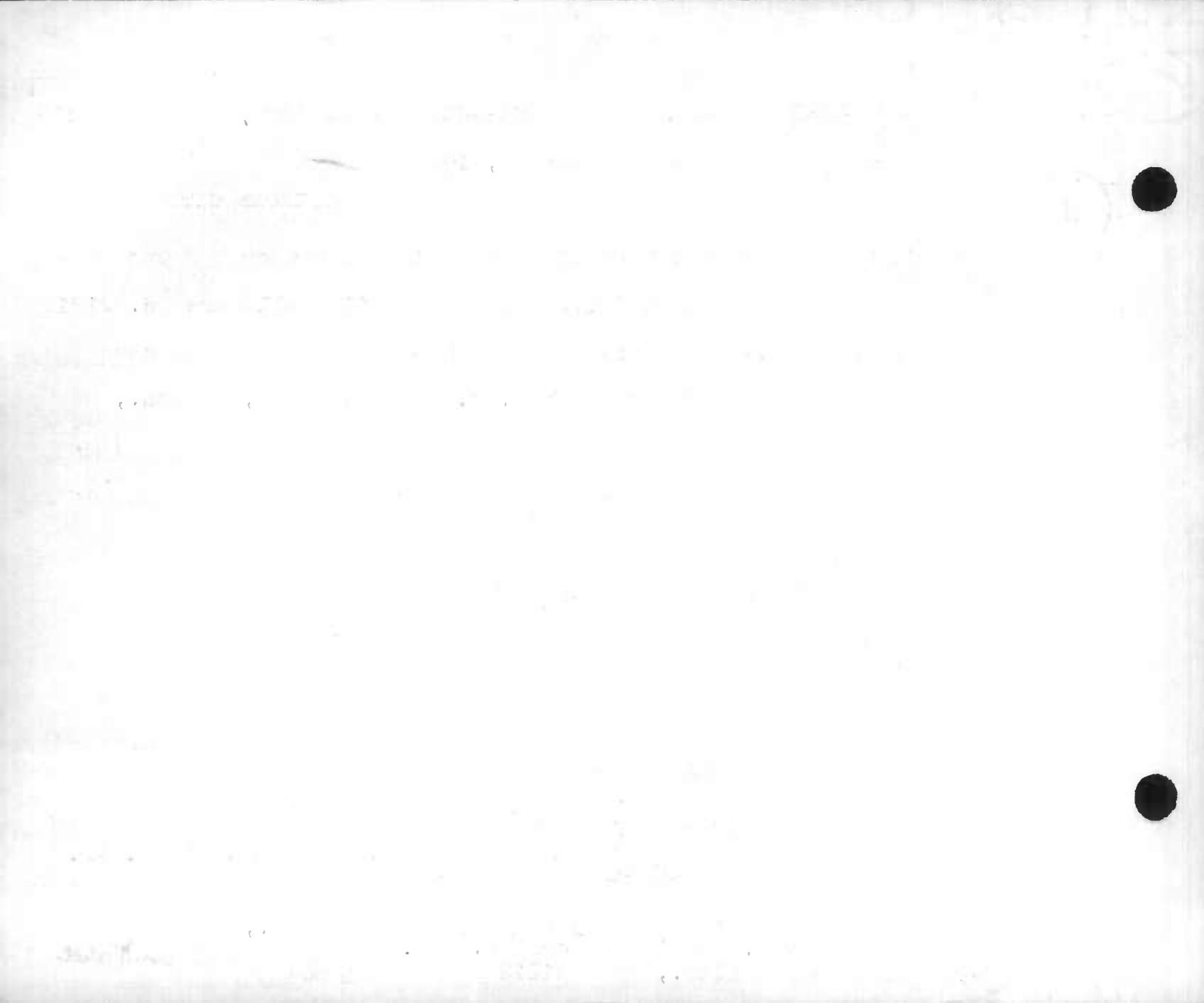
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by you, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

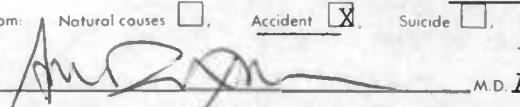
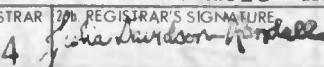
MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST ANNE	MIDDLE CARY	LAST WOODWARD	2a. DATE OF DEATH JUNE 13TH, 1984			MONTH YEAR	DAY	YEAR	2b. HOUR 11:50AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH July DAY 26 YEAR 1904			6. AGE (IN YEARS LAST BIRTHDAY) 76 79 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		8. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY						MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 118 Bellemore Rd. 21210				
14. FATHER'S NAME FIRST Wilson		MIDDLE Miles	LAST Cary	15. MOTHER'S MAIDEN NAME FIRST Helen			MIDDLE			LAST Lanahan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 076 38 0232		17. INFORMANT W. M. Cary Woodward, Balto., MD			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1hr				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4151		DUE TO, OR AS A CONSEQUENCE OF (b) Probable pulmonary embolus		DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Immobility (R) Lung (z)														
19a. DATE OF OPERATION 6/1/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) June 13 1984		21f. LOCATION STREET Johns Hopkins Hospital			CITY OR TOWN BALTO. MD.			COUNTY 21205			STATE	
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Schulke			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 6/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STREITEN SCHULKE		22e. ADDRESS 600 N. WOLFE ST. BALTO. MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/15/84		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount			23d. LOCATION CITY OR TOWN Balto.			COUNTY MD				
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR JUN 15 1984			25b. REGISTRAR'S SIGNATURE Richardson Pendleton							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MAR 1981, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR	
JOSEPH			J.	WOODWARD, IV	6 26 1984		M				M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 9 YEAR 62	6. AGE (IN YEARS (LAST BIRTHDAY) 21 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR 1:14 a.m.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.			
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU)			12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE] Office Work			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 258 Stanmore Rd. 21212							
14. FATHER'S NAME Joseph			MIDDLE J.	LAST Woodward III	15. MOTHER'S MAIDEN NAME Barbara		MIDDLE Gelston	LAST Woodward				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	16c. ADDRESS 215-94-9622			17. INFORMANT Mrs Sue Gelston		ADDRESS 14600 Woodbank La. 21131					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 11:50 M. 6-25- 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/fixed object impact.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET CITY OR TOWN York & Phoenix Rds.			COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>						and in my opinion			
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 6-26-84			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/29/84			23c. NAME OF CEMETERY OR CREMATORIAL Glenco Epis.Ch. Cemetery			23d. LOCATION CITY OR TOWN Sparks			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld			ADDRESS 6500 York Rd.			25a. DATE REC'D. BY REGISTRAR 111N 29 1984			25b. REGISTRAR'S SIGNATURE 			
BP												
DHMH - 17 (VR A15 ME (5)) 20M 4/B2												

CONFIDENTIAL

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EDWARD R. GOREY

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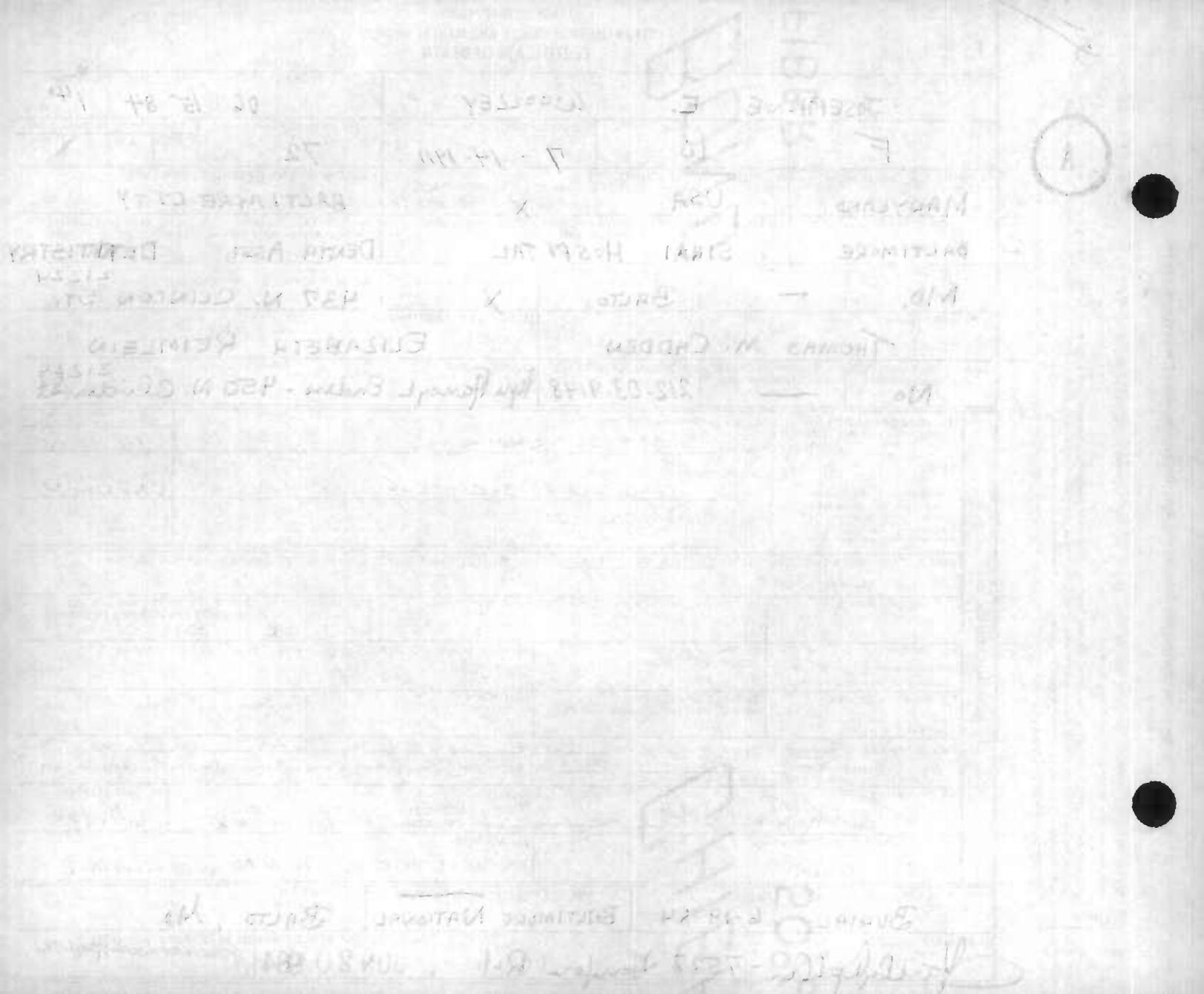
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 15 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																						
8 4 1 6 4 4 8											REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR										
JOSEPHINE E. WOOLLEY						06 15 84					14 ⁰	AM										
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.										
<input checked="" type="checkbox"/>		W		MONTH 07	DAY 14	YEAR 1911	72			YRS.												
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD.												
MARYLAND		USA																				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE		SENAY HOSPITAL										DENTAL ASST.		DENTISTRY								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21224										
13a. STATE MD.		13b. COUNTY —		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 437 N. CLINTON ST.													
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST											
THOMAS M. CADDEN						ELIZABETH REIMLEIN																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			21224												
No		212-03-9148		Anne Nancy L. Enders - 450 N. Clinton St.																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTIC SHOCK</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 hours										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>GANGRENE, DECUBITUS</u>												UNKNOWN										
DUE TO, OR AS A CONSEQUENCE OF (c) _____																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>CVA, CHF</u>																						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE											
22a. I certify that (1) this hospital attended the deceased from <u>6/13</u> 19 84 to <u>6/15</u> 19 84, that (2) we last saw the deceased alive on <u>6/15</u> 19 84, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If (1) we did not see the body after death, check here <input type="checkbox"/>																						
22b. SIGNATURE <u>Seth Weber</u>		DEGREE										22c. DATE SIGNED 6/15/84										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SETH WEBER		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>												23b. DATE 6-19-84		23c. NAME OF CEMETERY OR CREMATORIAL BALTMORE NATIONAL			23d. LOCATION CITY OR TOWN BALTO.		COUNTY MD.		STATE	
24. FUNERAL DIRECTOR NAME <u>Hartley Miller - 7527 Harford Rd.</u>												25a. DATE REC'D. BY REGISTRAR JUN 20 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell								



RECEIVED
MAY 10 1968



RECEIVED MAY 10 1968

RECEIVED MAY 10 1968

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 4 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 4 1 6 4 5 0		
1 - STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 6-30 19 84									2b. HOUR M		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST					
Henrietta			G.			Wright								
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. MARRIED WIDOWED <input checked="" type="checkbox"/>	10. NEVER MARRIED DIVORCED <input type="checkbox"/>	11. DATE PRONOUNCED DEAD	12. MONTH DAY YEAR	13. DATE MONTH DAY YEAR	14. HOUR P.M.			
Female	White	Jan. 16, 1904	80 yrs.					6-30 19 84		6-30 19 84	5:03 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,			MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Saleslady					
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Catonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5660 Calyn Road 21228			
14. FATHER'S NAME First: late Emmanuel			Middle: MIDDLE			Last: Gangloft			15. MOTHER'S MAIDEN NAME First: late					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 03 8036			17. INFORMANT Miss Michele Wright 2926 Woodwick Ct			ADDRESS: Ellicott City 21044					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Margarita Korell</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE July 2, 1984			23c. NAME OF CEMETERY OR CREMATORIUM Westview Memorial Pk.			23d. LOCATION CITY OR TOWN Catonsville			COUNTY Balto., Maryland		
24. FUNERAL DIRECTOR NAME Harry H Witzke 4112 Columbia Rd Ellicott City			25a. DATE REC'D. BY REGISTRAR JUL 2 - 1984									25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Witzke</i>		
ADDRESS														

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 15 GIVE TO ITEM 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, 3, 4 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

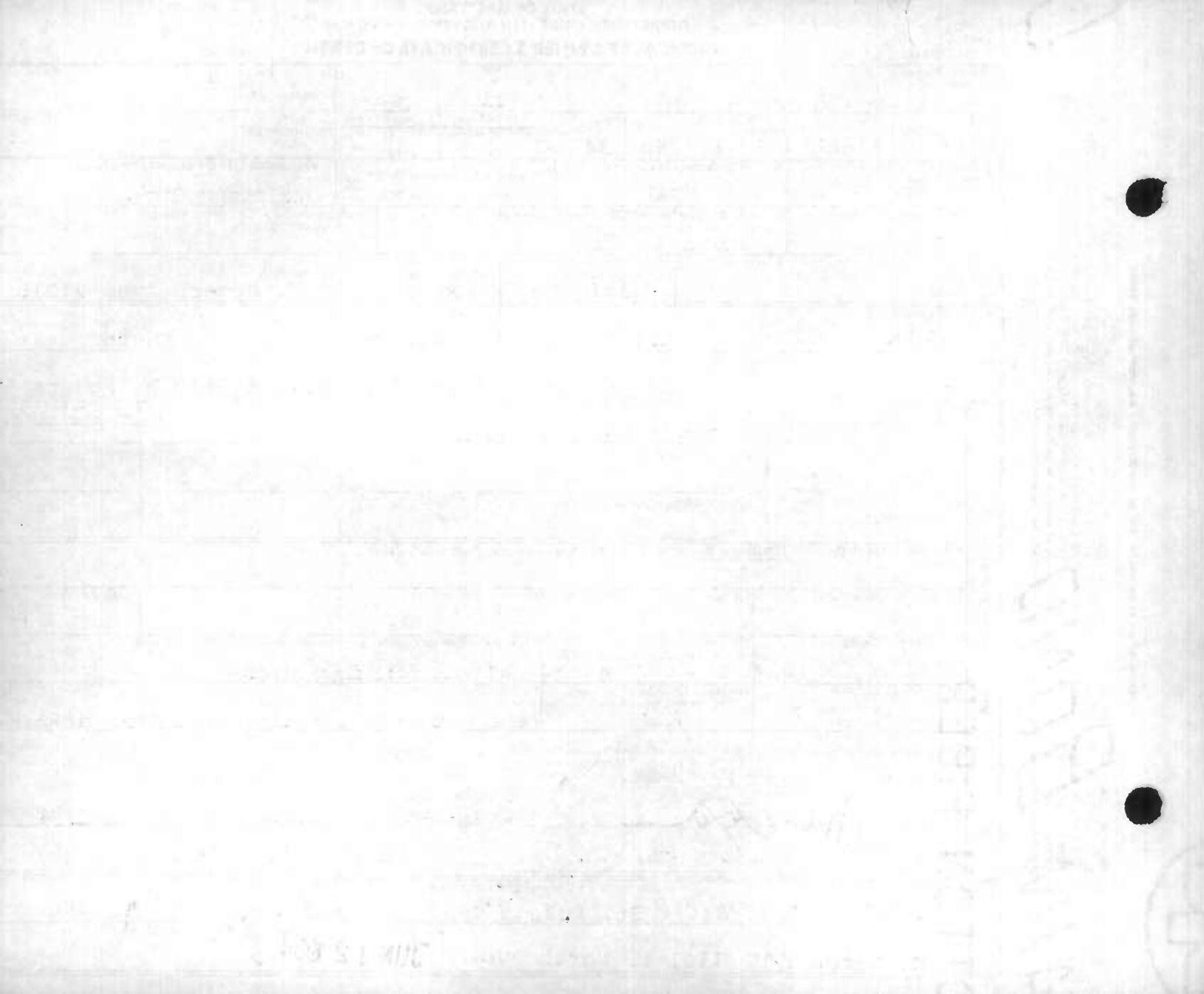
MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6416451

1. DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE H.	LAST Wright Jr.	2a. DATE OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 6 YEAR 1019 84	2b. HOUR 2d. HOUR M 9:35
3. SEX Male	4. RACE Black	S. DATE OF BIRTH MONTH 3 DAY 19 YEAR 50	6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS.	IF UNDER 1 YR. MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 6 10 19 84 a	2d. HOUR M 9:35	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3819 W. Rogers Ave. 21215		
14. FATHER'S NAME FIRST John			MIDDLE Wright	LAST Frances	15. MOTHER'S MAIDEN NAME FIRST Payne		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-54-1689		17. INFORMANT Frances R. Wright	ADDRESS 3819 W. Rogers A		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8809 IMMEDIATE CAUSE (a) <u>Cranio cerebral trauma</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY ? P.M. 6 4 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject fell down steps			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bank		21f. LOCATION STREET CITY OR TOWN Reisterstown Rd & Rogers Ave, Balto. City, Md	COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.							
ADDRESS 111 Penn St. Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/15/84	23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cem.		23d. LOCATION CITY OR TOWN Reisterstown		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTER JUN 12 1984		
25b. SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

154-7091

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial/transit permit). Then please remove carbon paper page 2 should be used without 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

IMPORTANT: If item 21 is marked or item 18 shows any injury, another return slip, the medical examiner will be notified.

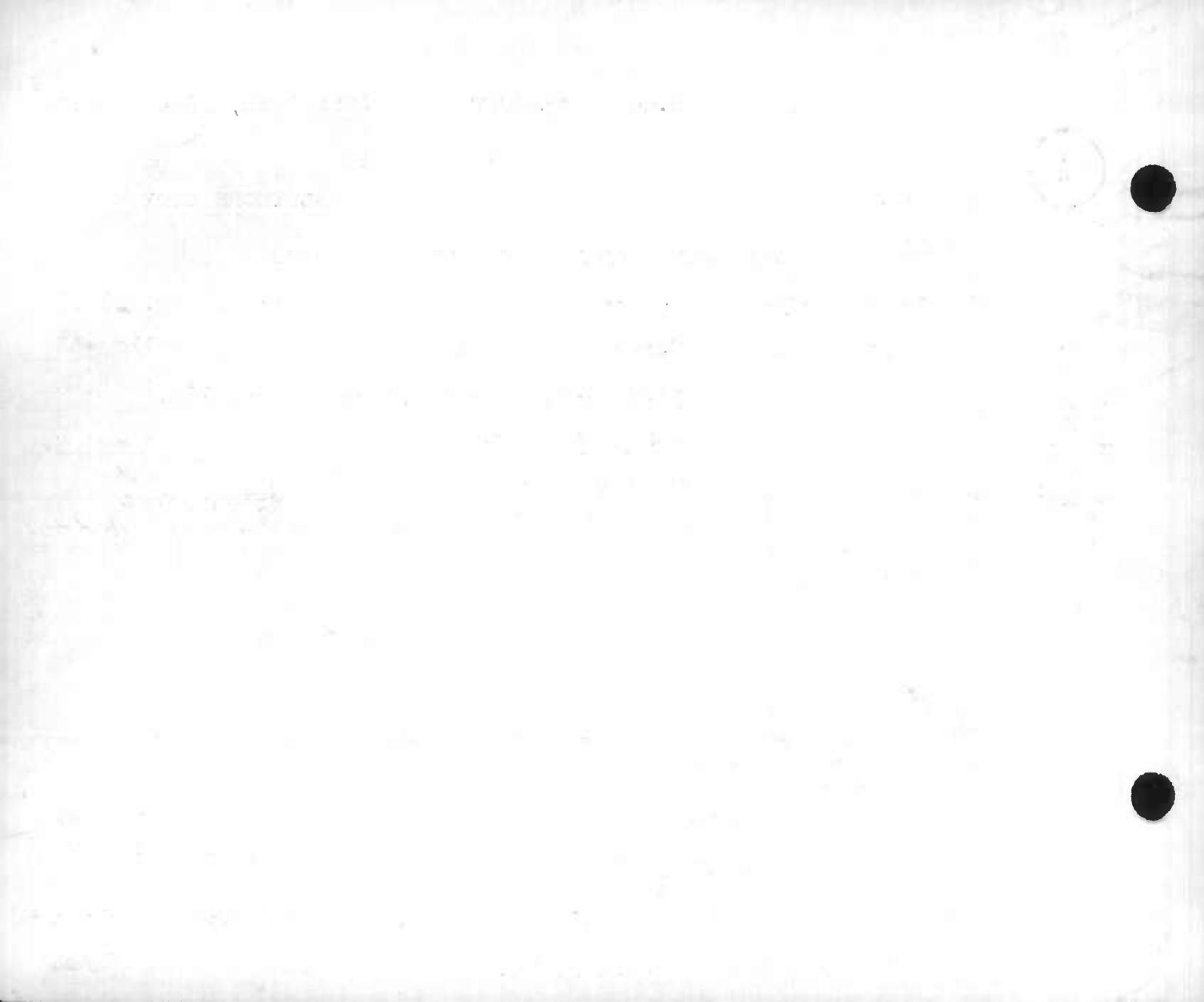
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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 4 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR P	
JULIE			A. nn		WRIGHT	JUNE 11TH, 1984			9:20 M		
3. SEX		4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
female		Caucasian	MONTH	DAY	YEAR	11	8	1967	16	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA						BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		THE JOHNS HOPKINS HOSPITAL			Student						
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Talbot		Easton				521 Hazelwood Dr. /21601			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Robert	L.	Wright	Yvonne				Hallowell		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		214-78-4671		Yvonne H. Ross		see 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 3229 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes											
DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN STEM ISCHEMIA 5d											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost											
DUE TO, OR AS A CONSEQUENCE OF (c) MENINGITIS, SINUSITIS, INCREASED PRESSURE 16 days INTRACRANIAL											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). URINARY TRACT INFECTION											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from 6/11/84 19 07 to 6/11/84 19 07, that (I) (we) lost saw the deceased alive on 6/11/84 19 07, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b SIGNATURE <i>Gregory P. Harris</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 6/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GREGORY P. HARRIS</i>		22e. ADDRESS THE JOHNS HOPKINS HOSPITAL 601 N. Wolfe St. Baltimore, Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-14-84			23d. LOCATION CITY OR TOWN Federalsburg	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR JUN 15 1984			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Pandelle</i>				



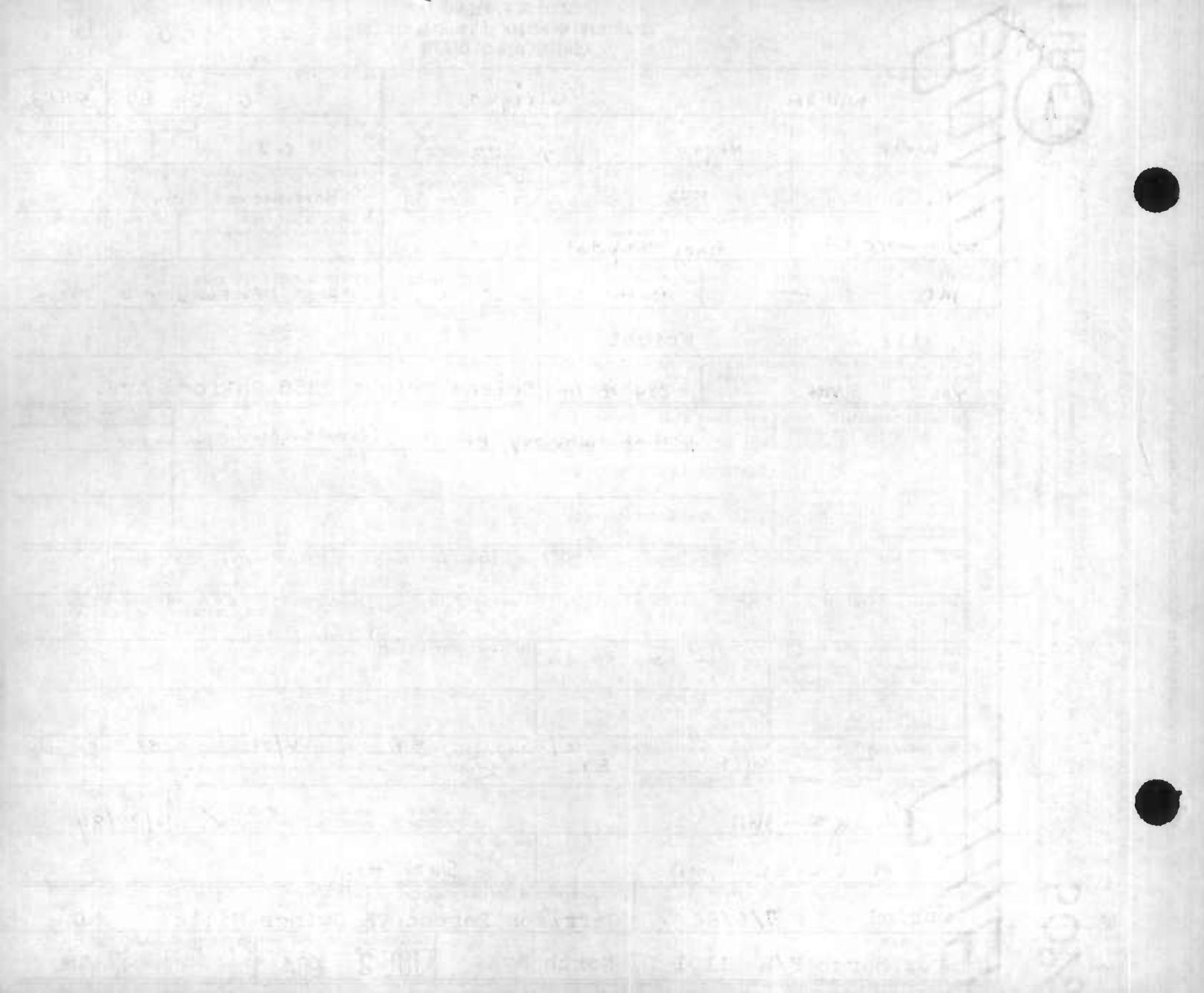
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 . 5 3			
												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR		
			William			Wright			6 29 84				541 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			Negro			MONTH DAY YEAR			62			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.			USA			7 23 21						Baltimore city MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore city			Sinai Hospital												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD						Balto						2850 OAKFORD AVE 21215			
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
First Will			Wright												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
YES			244 18 7164			Selena Wright			2850 Oakford Ave,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> ?Embolism, defective pulmonary valve												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
{ DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>84</u> , to <u>6/29</u> , 19 <u>84</u> , that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <u>R. M. Cooper MD</u> DEGREE												22c. DATE SIGNED <u>6/29/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
R. M. COOPER MD			Sinai Hosp.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			7/6/84			Garrison Forest VA Owings Mills									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Wm. C. March F/H			1101 E. North Ave.			JUL 2 1984			Julia Davidson-Randall						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remit carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Yes" it shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 4 5 4			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Willie</i>	MIDDLE <i>Mae</i>	LAST <i>Wright</i>	2a. DATE OF DEATH			MONTH JUL	DAY 24	YEAR 1984	2b. HOUR 58 ¹⁵			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Black		MONTH 7	DAY 1	YEAR 21	62	YRS.	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE COUNTRY <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>C. Ty.</i>			MD.					
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS <i>140 W. Lafayette Ave.</i>			21217			
14. FATHER'S NAME FIRST <i>Unkn.</i>				15. MOTHER'S MAIDEN NAME FIRST <i></i>			ADDRESS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Unkn.</i>				16b. SOCIAL SECURITY NO. <i>126-52-3370</i>			17. INFORMANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac - pulmonary arrest</i>															
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic organic brain syndrome</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Rt arm edema</i> ?															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>Hypertension</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>31st</i>			CITY OR TOWN <i>Balto.</i>	COUNTY <i>Md.</i>	STATE <i>Md.</i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>6/23/84</i> , to <i>6/24/84</i> , that (I) (we) last saw the deceased alive on <i>6/23/84</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>6/24/84</i>			
22b. SIGNATURE <i>Dr. Tolman</i>			22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Tolman</i>			22e. ADDRESS <i>Obremannan</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>6/27/84</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Balto., Md.</i>			23d. LOCATION CITY OR TOWN <i>JUL</i>			23e. COUNTY <i>Md.</i>		STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Irvin P. Carroll F. H.</i>			ADDRESS <i>Balto., Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>2-1984</i>			25b. REGISTRAR'S SIGNATURE <i>Juli Davidson-Pendleton</i>						

2000 C.G.C. DM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

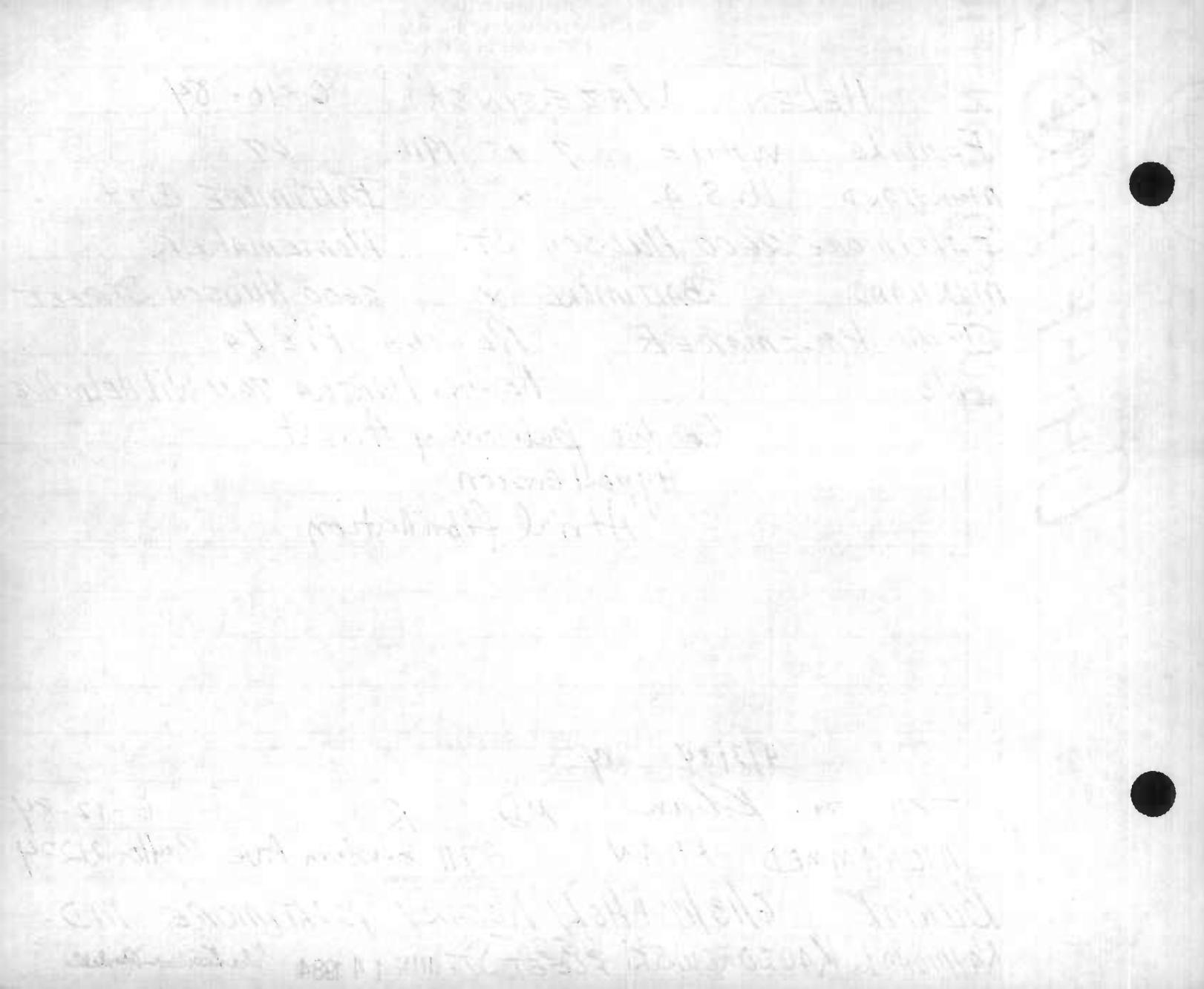
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 4 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>HELEN WRZESINSKI</i>						<i>6-10-84</i>						
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			M		
<i>FEMALE</i>			<i>WHITE</i>	MONTH	DAY	YEAR	UNDER 1 YEAR	IF UNDER 24 HRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
<i>MARYLAND</i>			<i>U. S. A.</i>						<i>BALTIMORE CITY</i>			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>BALTIMORE</i>			<i>2600 HUDSON ST.</i>			<i>HOMEKEEPER</i>			<i>21224</i>			
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
<i>MARYLAND</i>			<i>BALTIMORE</i>						<i>2600 HUDSON STREET</i>			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
<i>JOHN KACZMAREK</i>					<i>REGINA PIELA</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
<i>NO</i>						<i>REGINA HARTKA</i>			<i>7611 WILHELM AVE</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
<i>Cardio-pulmonary Arrest</i>												
PART II. DISEASE OR CONDITION WHICH LED TO DEATH (b) <i>Hypertension</i>												
(c) <i>Atrial fibrillation</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART II)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/3/84</i> to <i>19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>M. Khan</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6-12-84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MOHAMMED KHAN</i>			22e. ADDRESS <i>2711 Eastern Ave Baltimore 21224</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>6/13/1984</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>HOLY ROSARY</i>			23d. LOCATION CITY OR TOWN <i>BALTIMORE MD.</i>			
24. FUNERAL DIRECTOR NAME <i>RAYMOND L. KACZOROWSKI</i>			ADDRESS <i>2525 FLEET ST.</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 14 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Suzanne Davidson Pendleton</i>			

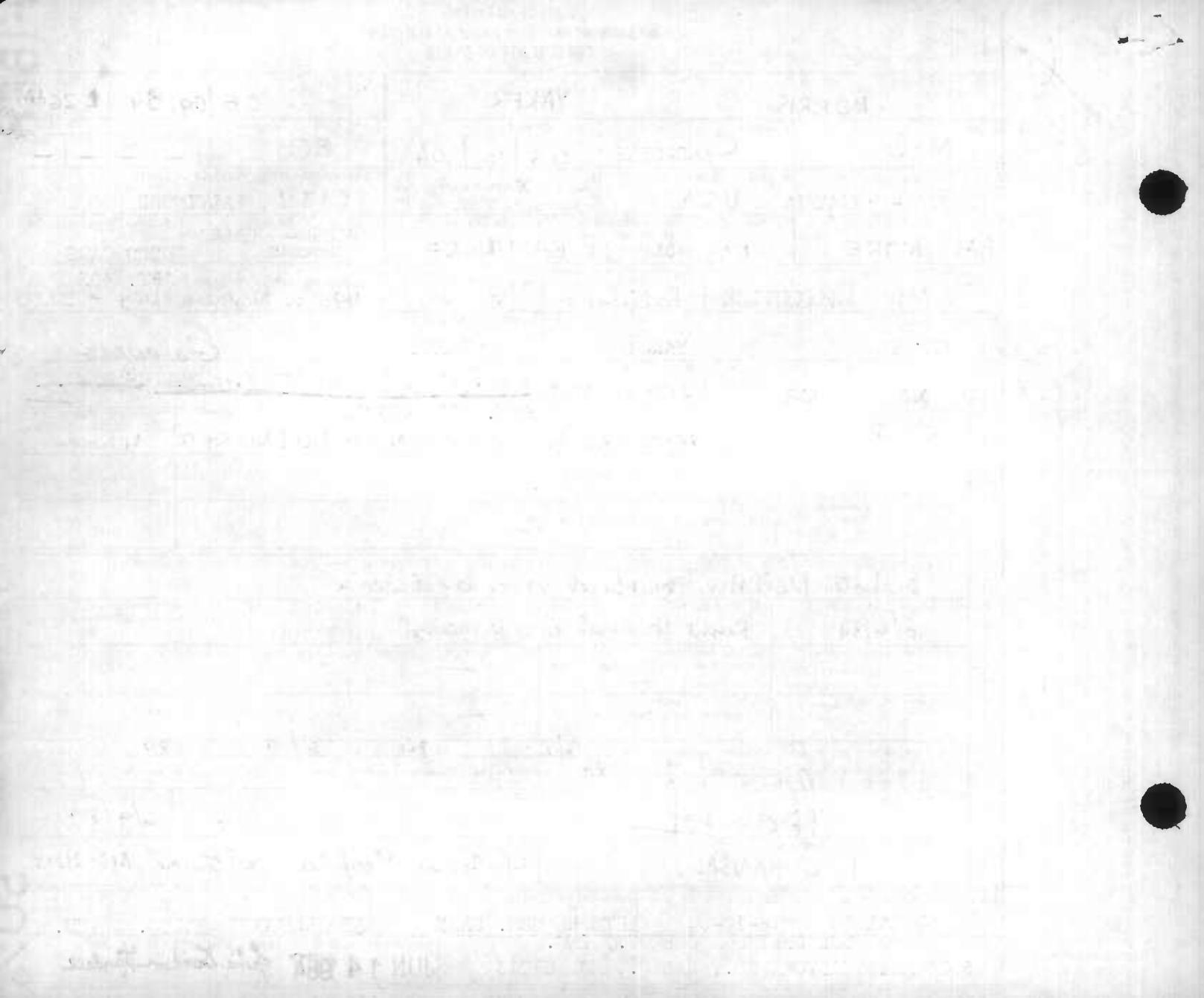


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-formal permit. Then please remove carbon copies. Page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or either traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 4 5 6	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			MORRIS			YAKER			06/09/84			2:26 AM M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.	
Male			CAUCASIAN			05/10/04			80 YRS.			— — — —	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH CITY, BALTIMORE MD.				
RUSSIA - ROUMANIA			USA										
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP. OF BALTIMORE			12a. USUAL OCCUPATION OWNER DEALER XXXXXX			12b. KIND OF BUSINESS OR INDUSTRY USED CARS				
13a. STATE MD			13b. COUNTY XXXXXXX			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE APT. 423 1190 W. Northern Pkwy - 21210	
14. FATHER'S NAME SAMUEL			15. MOTHER'S MAIDEN NAME MIRIAM									GARDNER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO. XXX-01-3949A			17. INFORMANT MRS. IRENE YAKER APT. 423 #21210			ADDRESS 1190 W. NORTHERN PKWY BALTIMORE MD. Plaza Center - 3115			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			MYOCARDIAL INFARCTION, CARDIOGENIC SHOCK										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:													
Diabetes Mellitus, Peripheral vascular disease													
19a. DATE OF OPERATION 6/6/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right femoral insufficiency			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6/9			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/2, 1984, to 6/9, 1984, that (I) (we) last saw the deceased alive on 6/9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Bansal			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 6/9/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. K. BANSAL			22e. ADDRESS 90 Sinai Hospital, Baltimore, MD-21215										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-10-84			23c. NAME OF CEMETERY OR CREMATORIAL BETH EL MEM. PARK			23d. LOCATION CITY OR TOWN RANDALLSTOWN BALTO.			COUNTY STATE	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215									25a. DATE REC'D. BY REGISTRAR JUN 14 1984			REGISTRAR'S SIGNATURE Julie Davidson Pendell	



TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been issued by the State Dept. of Health and Mental Hygiene.

TO FUNERAL DIRECTOR: All this certificate has been issued by the State Dept. of Health and Mental Hygiene. It should be detached from this form and sent to the funeral director. If Item 21 is marked or Item 18 shows any injury, other than traumatic, the attending physician should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 16457					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR JUNE 13, 1984							2b. HOUR 11:23A					
1. DECEASED NAME FIRST ANNIE L. MIDDLE YANCEY LAST															
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 12 DAY 22 YEAR 16			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			# UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.								
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE JOHNS HOPKINS HOSPITAL							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 704 N. Montford Ave. 21205					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 243-20-7904		17. INFORMANT Charles Yancey			ADDRESS 704 N. Montford Avenue								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4589										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11:23 AM					
DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension										2½ days					
DUE TO, OR AS A CONSEQUENCE OF (c) Septic Shock										3 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). HYPERKALEMIA, RENAL FAILURE															
19a. DATE OF OPERATION 6/11/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Septic Shock							20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from JUNE 10, 1984, to JUNE 13, 1984, that (I) (we) last saw the deceased alive on JUNE 13, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 6/13/84					
22b. SIGNATURE William L. Sigmond		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM SIGMUND		22e. ADDRESS JOHNS HOPKINS HOSPITAL													
23a. BURIAL, CREMATION, REMOVAL (BURIAL)		23b. DATE 6/16/84		23c. NAME OF CEMETERY OR CREMATORIAL Eastview Mem. Pk.			23d. LOCATION CITY OR TOWN Baltimore,		COUNTY Md.		STATE				
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue ADDRESS												25a. DATE REC'D. BY REGISTRAR JUN 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TS UK 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Space 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

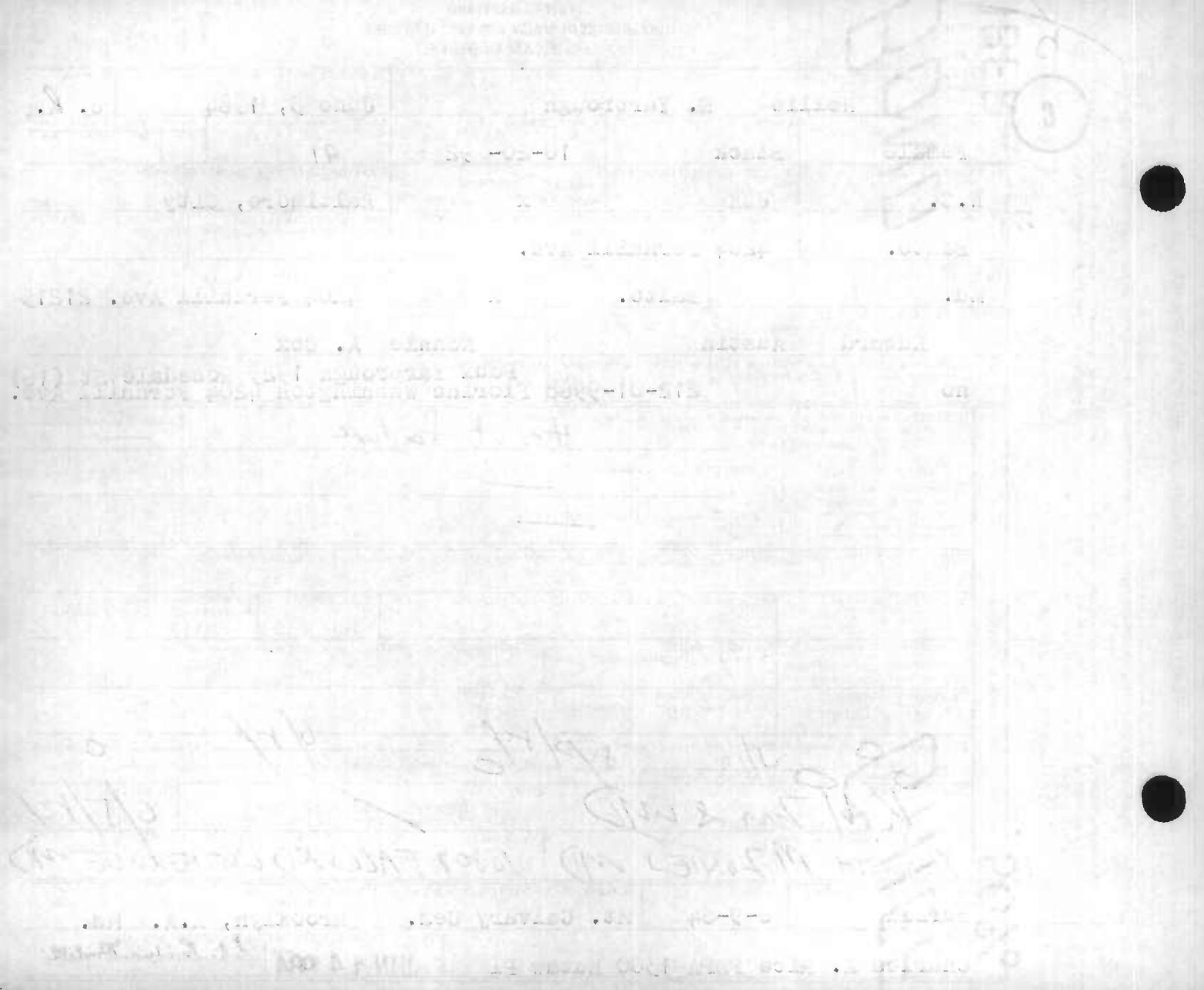
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8416458

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Nellie E. Yarbrough						June 3, 1984				6. 6 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Female		Black		10-20- 92			91							
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
N.C.		USA					Baltimore, City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Balto.		4204 Fernhill Ave.												
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4204 Fernhill Ave. 21215				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Edward		Austin		Nannie A. Cox										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Paul Yarbrough			ADDRESS 1925 Rosedale St (16)							
no		212-01-9968					Florine Washington			4204 Fernhill Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4289														
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 410			21f. LOCATION STREET 573189 CITY OR TOWN 604 COUNTY 19 STATE MD									
22a. I certify that (in this hospital) attended the deceased from 4/10 to 5/3/84 , 19_____, to 6/4 , 19_____, that (we) last saw the deceased alive on 4/10 , 19_____, and that (our) opinion death occurred on the date and hour and from the causes stated above. (In we did) did not view the body after death.														
22b. SIGNATURE Kenneth M. Zonies MD		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/5/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth M. Zonies MD		22e. ADDRESS 10807 FALES RD LUTHERVILLE MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-9-84		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cem.			23d. LOCATION CITY OR TOWN Brooklyn, A.A. Md. COUNTY STATE							
24. FUNERAL DIRECTOR NAME Charles A. Rice FSPA		ADDRESS 1300 Eutaw Pl			25a. DATE REC'D. BY REGISTRAR JUN 14 1984			25b. REGISTRAR'S SIGNATURE Sylvia Lindstrom Pendleton						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8 4 1 6 4 5 9											
1. DECEASED NAME (TYPE OR PRINT)			FIRST HANNA	MIDDLE	LAST YLINEN	2a. DATE OF DEATH			MONTH June	DAY 12	YEAR 1984
1. SEX			4. RACE		5. DATE OF BIRTH	MONTH Sept.	DAY 24	YEAR 1896	6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	87 YRS.			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Finland			7b. CITIZEN OF WHAT COUNTRY? Finland		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.						
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) 536 S. Lehigh Street - 21224		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 536 S. Lehigh Street-21224			
14. FATHER'S NAME FIRST (unknown)			MIDDLE	LAST Pyhalahhti	15. MOTHER'S MAIDEN NAME FIRST Mariana			MIDDLE	LAST Linna		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-32-3155		17. INFORMANT Mrs. Martha Raukko-1107 N."M" St. Lake Worth,			ADDRESS -Fla. 33460			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN											
4019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION 144MS DOUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 5721			CITY OR TOWN 19 69	COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from 3/25 19 69 to 3/25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (do) (did) (did not) view the body after death.											
22b. SIGNATURE Louis O. Olsen, M.D. DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22c. DATE SIGNED 6/13/84			22e. ADDRESS 1012 Old North Point Road - 21224								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 16, 1984		23c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN CEMETERY			23d. LOCATION CITY OR TOWN Baltimore Co., Md.-21224		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Henry Sander & Sons, Inc., Balt., Md. 21213			ADDRESS		25a. DATE REC'D BY REGISTRAR JUN 13 1984			25b. REGISTRATION NUMBER Luna Davidson #1000			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 6 4 6 0

REG. NO.

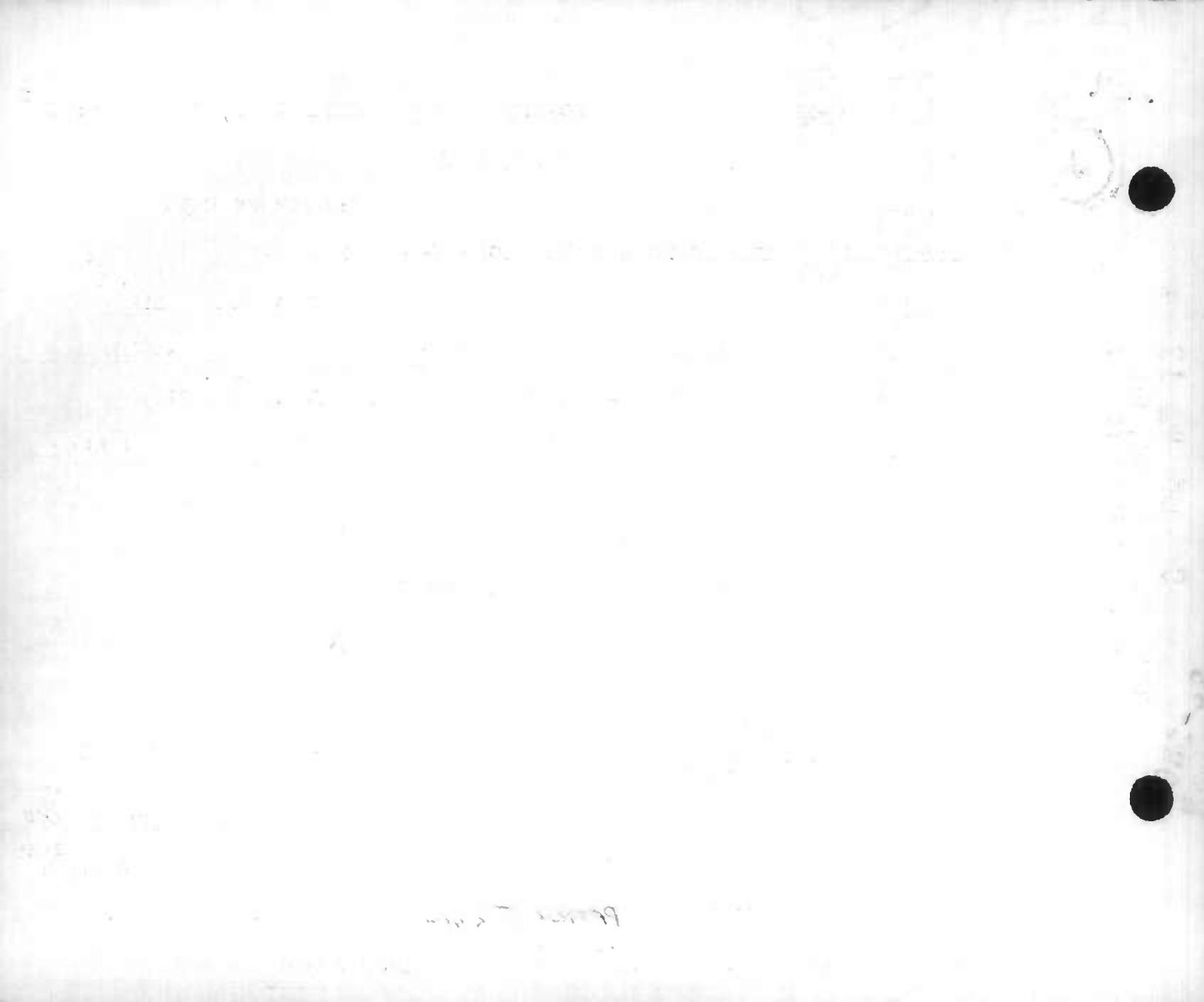
1 FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR										2b HOUR					
		1. DECEASED NAME			FIRST		MIDDLE		LAST		JUNE 21ST, 1984			8:05 M			
		GWEN YOFFEE															
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE		WHITE			MONTH DAY YEAR			68			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD.						
MARYLAND		USA			MAY 3, 1916			BALTIMORE CITY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
BALTIMORE		THE JOHNS HOPKINS HOSPITAL						HOUSEWIFE			AT HOME						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		APT. C							
MARYLAND				BALTIMORE				6430 ELRAY DR.		21209							
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		UNKNOWN							
		MAX				PETERS		FIRST HARRIET									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APT. C							
NO				219-03-1786		6430 ELRAY DR. BALTO., MD 21209		ADULT RESPIRATORY DISTRESS SYNDROME & PROFOUND HYPOTENSION									
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA		DUE TO, OR AS A CONSEQUENCE OF (c) MULTPLY RESISTANT PATHOGENS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										1 WEEK							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) <input type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <u>JUNE 21, 1984</u> , and that in my <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) (did not) view the body after death.					22b. SIGNATURE <i>Thomas Adams Corson M.D.</i>			22c. DEGREE		22d. DATE SIGNED <u>June 21, 1984</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		21205						
Thomas Adams Corson, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/24/84		23c. NAME OF CEMETERY OR CREMATORIAL PETACH TIKVAH		23d. LOCATION ROSEDALE		23e. BALTO.		MD							
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JUN 27 1984		25b. REGISTRAR'S SIGNATURE <i>nia Davidson-Purcell</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that you be advised by the attending physician.

TO FUNERAL DIRECTOR: Please sign and date this certificate. This document contains carbon paper. Pages 1 and 2 should be detached for use as the burial record sheet. This document contains carbon paper. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, air removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be called at once.

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR
JAMES				YOUNG				XX		6-6-84 19		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH DAY YEAR	11. DATE PRONOUNCED DEAD	12. MONTH DAY YEAR	13. TIME	14. HOUR	
MALE	BLACK	4 30 40	44 yrs.	MONTHS DAYS	HOURS MIN.	6-6-84	19	12:31				
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		USA						Baltimore City				
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		Provident Hospital										
SPECIAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MARYLAND				BALTIMORE				40 BENKURT AVENUE 21229				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
NORMAN				YOUNG		VIOLA						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		220-38-7078		MARION E. YOUNG		40 BENKURT AVE.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular 4029 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		<u>Margarita Korell</u>		TITLE (SPECIFY) M.D.		Assistant		MEDICAL EXAMINER		DATE SIGNED		
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS		111 Penn Street				6-6-84		
23a. BURIAL, Cremation, Removal (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR Crematory		23d. LOCATION CITY/TOWN		23e. STATE				
Burial 6/12/84 Urnitus Mem. Y.												
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Bailey Funeral Home 1348 N. Calhoun St.				JUN 8 1984								

DIVISION OF VITAI RECORDS 201 W PRESTON ST BALTIMORE MD 21280

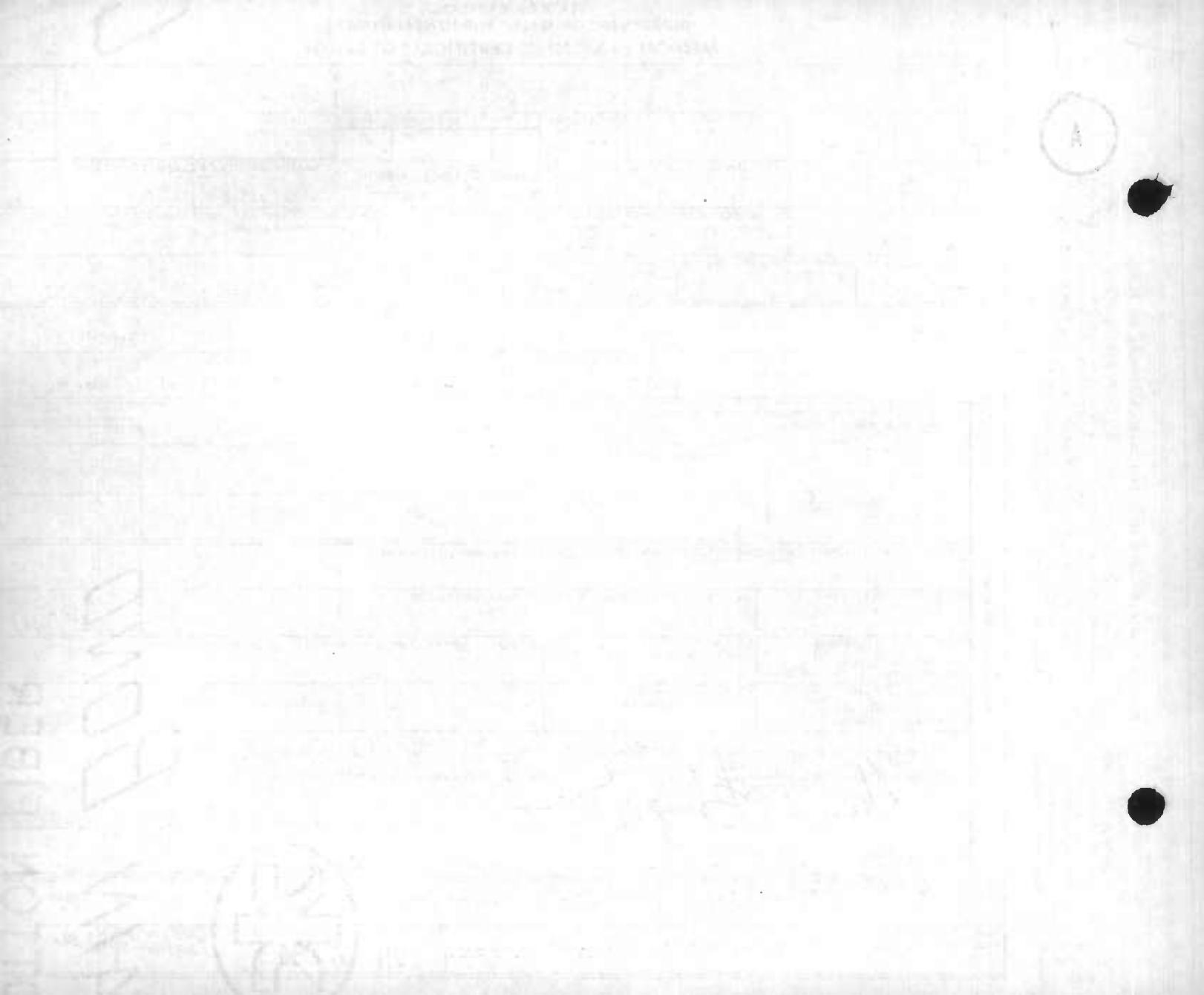
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR OUTLINES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 211 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5
20M 4/82



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 4 WITH FORM PA. 3 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 16462					
1- STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR					
(TYPE OR PRINT)			Michael A. Young						6-2 19 84			M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR		
male		black		7 6 56		27 yrs.						6-2 19 84			3:57 p.m.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
New Jersey			U.S.A.										Baltimore City,			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			Sinai Hospital														
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland					Baltimore				4027 Fairview Ave. 21216								
14. FATHER'S NAME			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME										
Erving					Young, Jr.		Bessie					Fludd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS					
NO			217-66-6584						Bessie Young			4027 Fairview Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3989 IMMEDIATE CAUSE (a) Rheumatic Heart Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? (head & chest) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Dennis F. Smyth, M.D.			TITLE (SPECIFY) M.D. Assistant									MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D.									ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 6/8/84			23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			23d. LOCATION Baltimore Co., Md.			STATE					
24. FUNERAL DIRECTOR Wm. March F/H Inc.			ADDRESS 1101 E North Avenue			25a. DATE REC'D. BY REGISTRAR 6/19/84			25b. REGISTRAR'S SIGNATURE								
BP																	
DHMH - 17 (VR A15 ME (5)) 20M 4/82																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Please do so.

BY HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the attending physician. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon paper. Pages 1 and 2 should be retained for use at the burial/funeral service. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18 show any injury, or other traumatic event, no medical treatment in hospital or medical facility in the last 24 hours.

MEDICAL CERTIFICATION

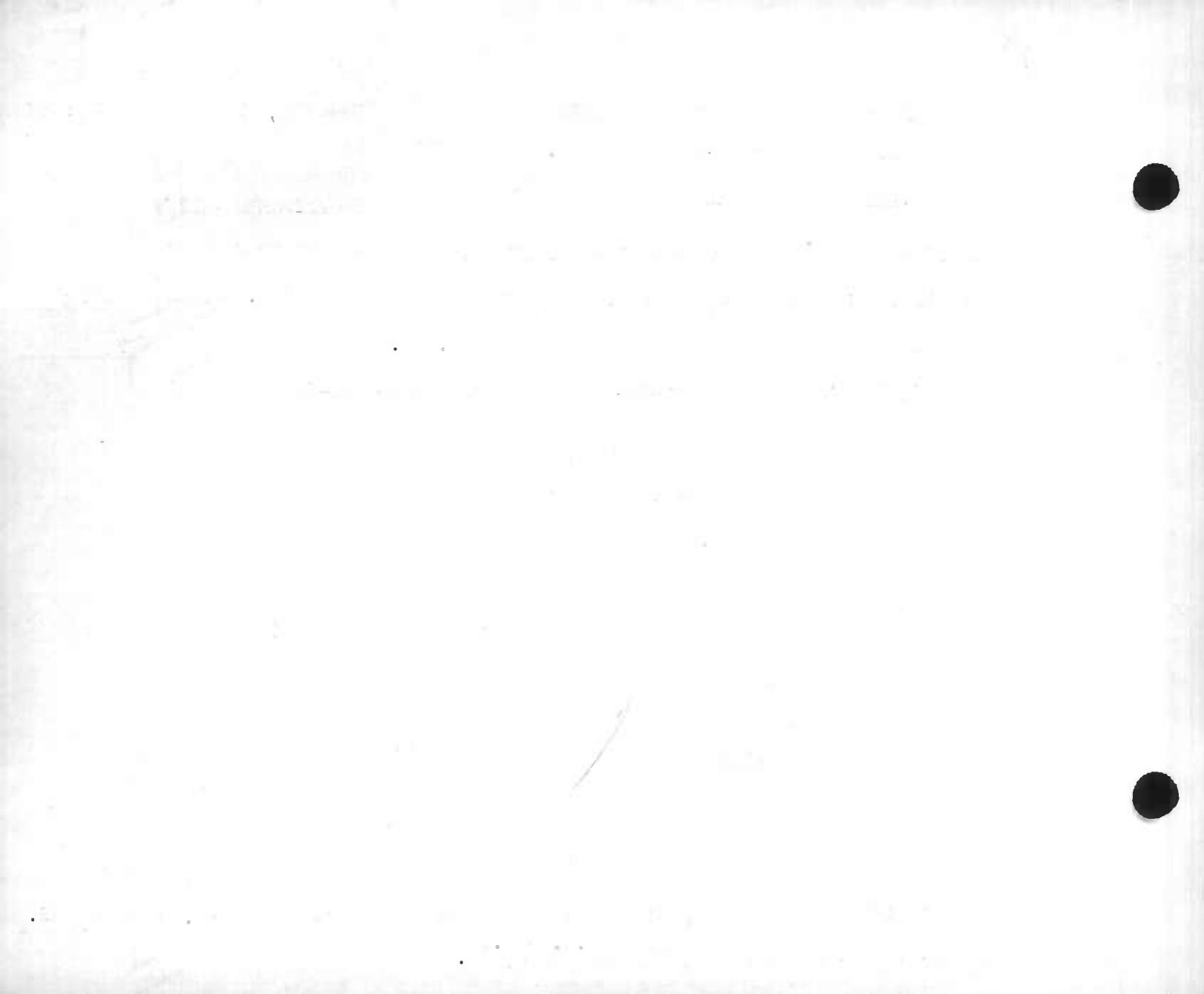
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 4 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
CHOK	Y	YUEN		JUNE 15, 1984				11:09 PM		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. HOUR		
Male	Oriental	Jan.	4	1936	48	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
China	USA	X	NEVER MARRIED	<input type="checkbox"/>	Divorced	<input type="checkbox"/>	BALTIMORE CITY	MD.		
9. YRS.										
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	JOHNS HOPKINS HOSPITAL			Restaurateur						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland	Prince George	Seabrook	F. K.			6505 96th. Avenue 20706				
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			LAST				
Ming		Yuen	Moy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? EYES, NO OR UNKNOWN: <input type="checkbox"/> YES, ONE WAR OR DATES: N/A	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS					
N/A	212-64-2650	Man Kei Yuen-wife-(same as 13e)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>Respiratory Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one Hour</i>										
<i>1550</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>Hepatoma</i> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
19b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/14</i> , 19 <i>84</i> , to <i>6/15</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>6/15</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.										22c. DATE SIGNED <i>6/16/84</i>
22b. SIGNATURE <i>James E. Greenwald</i>			DEGREE <i>MD PhD</i>	ATTENDING PHYSICIAN	<input type="checkbox"/>	MEDICAL DIRECTOR	<input type="checkbox"/>	STAFF PHYSICIAN	<input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)	22d. ADDRESS									
James E. Greenwald	Johns Hopkins Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial	June 20, 1984	George Washington			Adelphi			Pr. Georges	Md.	
24. FUNERAL DIRECTOR NAME	11800 N.H. Ave. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi Funeral Home				JUN 19 1984			<i>Julia Davidson-Randall</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. This please advise. (Signature) _____ Date _____

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, than the medical certification section must be completed.

03/11/95

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
CATHERINE			H.	ZALENSKI		JUNE			12,	1984		9:58 AM		
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			
Female			Cauc.		3/11/05						79 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 YEAR MONTHS DAYS			
Phila, Pa.			USA					BALTIMORE CITY MD.						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE			THE JOHNS HOPKINS HOSPITAL		Secretary			B&O Railroad						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS		
13a. STATE Md.	13b. COUNTY -	13c. CITY OR TOWN Balto.							3046 Mayfield Ave. 21213					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST					
Patrick Harrison					Annie Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO			-		176-18-0330			Jr. Frank Lechert, 8106 Candle La. 21237			—			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>														
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>respiratory failure</u> (c) <u>after right upper lobectomy</u> 2 wks 2 wks														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>recent colectomy for adenocarcinoma</u>														
19a. DATE OF OPERATION 5/29/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED a denocarcinoma			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>5/7/84</u> , to <u>6/12/84</u> , that (I) (we) last saw the deceased alive on <u>6/12/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b. SIGNATURE <u>Sarr MD</u> DEGREE														
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 6/12/84														
22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael G. Sarr</u> 22e. ADDRESS <u>600 N. WOLFE ST. BALTO, MD.</u> <u>Dept Surg Johns Hopkins Hosp. Balto, MD.</u> 21205														
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 6/15/84		23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith			23d. LOCATION CITY OR TOWN Balto., Md.			COUNTY STATE			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213			25a. DATE REC'D. BY REGISTRAR JUN 15 1984			25b. REGISTRAR'S SIGNATURE <u>Jane Davidson</u>								

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

A

april 1968 page 25 home trip

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR FUTURE REFERENCE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

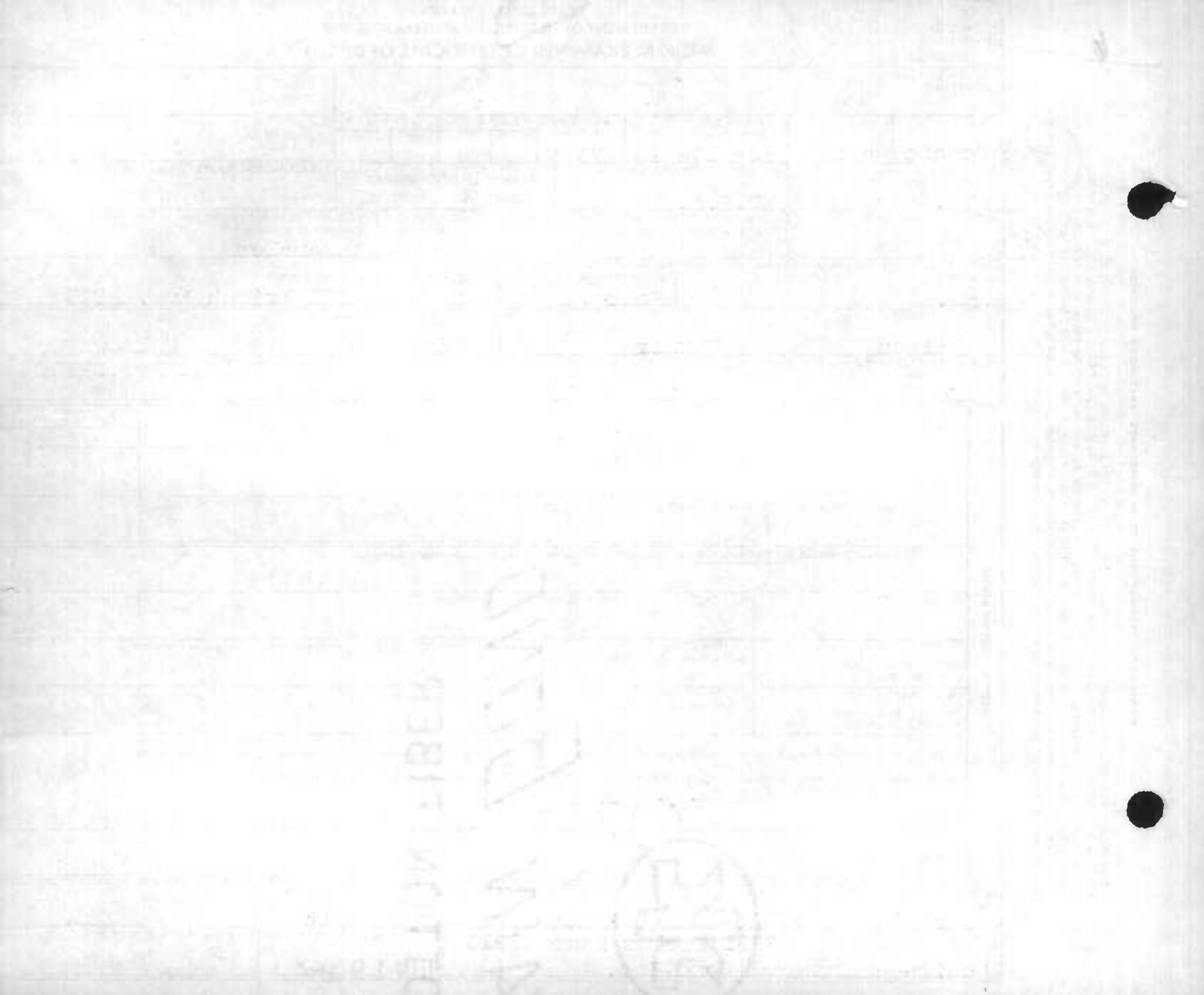
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6465	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		
Lawrence Michael Zelechowski											<input checked="" type="checkbox"/> MONTH DAY YEAR 6/16/84 19		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2b. HOUR MONTH DAY YEAR 12:20 AM	
MALE		WHITE		April 28, 1966		18						12:20 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
Balto. Maryland		U.S.A.											
9. BALTIMORE CITY OR COUNTY OF DEATH		Baltimore City										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		University Hospital Shock Trauma Student										12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air (21014)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1400 Turret Drive		21014			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Francis		John		Zelechowski		Patricia		Lucille		Barsch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		-		218-58-2502		Mr. Francis J. Zelechowski		1400 Turret Drive					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		Cranio-cerebral & Neck Trauma											
8122		DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
{		(b)											
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20. AUTOPSY?							
7:15xx 6/15/84		subject motorcyclist struck by auto		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
Roadway		Rt. 24, Forest Hills, Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE		TITLE (SPECIFY)											
EXAMINER'S NAME (TYPE OR PRINT)		M.D. Assistant MEDICAL EXAMINER											
Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
Burial		JUNE 19, 1984		OAK LAWN CEMETERY		Baltimore, Maryland							
24. FUNERAL DIRECTOR		ADDRESS		24. DATE RECD BY REGISTRAR		25. REGISTRAR'S SIGNATURE							
Joseph William Foster		50 W. Broadway & Williams St.		JUN 20 1984		Julie Davidson Rendell							
Joseph William Foster		Bel Air, Maryland 21014											
BP													
DHMH - 17													
(VR A15 ME (5))													
20M 4/82													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6466					
1. STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST									2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 6/14/84 19					
			Myrtle H. ZELLER									2b. HOUR 24 HOUR 2:25 PM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6/14/84 19				
Female		White		10- 17- 10			73 yrs.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
Va.			U.S.A.												MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4821 Wright Ave.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4821 Wright Ave. 21205								
14. FATHER'S NAME FIRST Wilbur			MIDDLE		LAST Turner		15. MOTHER'S MAIDEN NAME FIRST Elizabeth		MIDDLE		LAST Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN No			16b. SOCIAL SECURITY NO. 217-34-3050A									17. INFORMANT ADDRESS 5036 Wright Ave. 21205			George Doenges		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). 19a. DATE OF OPERATION															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE _____						TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 6/14/84					
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-18-84			23c. NAME OF CEMETERY OR CREMATORIAL ADD. Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN Balto.			COUNTY STATE Md.					
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc.			3331 Brehms Lane 21213			25a. DATE REC'D. BY REGISTRAR JUN 19 1984			25b. REGISTRAR'S SIGNATURE Neiliah Rendall								
BP _____																	
DHMH - 17																	
(VR A15 ME (5))																	
20M 4/82																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 4 1 6 4 6 1	REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Anna</i>	MIDDLE <i>Marie</i>	LAST <i>Zer Foss</i>	2a. DATE OF DEATH <i>6-3-84</i>	MONTH YEAR	2b. HOUR <i>1 PM</i>
3. SEX Female		4. RACE White	5. DATE OF BIRTH 3 29 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80	IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deacon Med Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13. STATE Md.		13b. COUNTY M.A.A.		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14 W 11th Ave. 21225
14. FATHER'S NAME Anthony		MIDDLE 	LAST Petcavage	15. MOTHER'S MAIDEN NAME Mary		MIDDLE 	16. LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 061-12-4061		17. INFORMANT Leona Doegen (same as 13e)		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell carcinoma of lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3mo								
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. chronic obstructive pulmonary disease, gout, arthritis, peptic ulcer.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from May 30, 1984 , to June 3, 1984 , that (1) (we) last saw the deceased alive on June 1, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Steven Luke MD</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED June 4, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Luke		22e. ADDRESS 22 So Greene St. Baltimore MD						
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 6/4/84		23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem.		23d. LOCATION CITY OR TOWN Balto. Md.		
24. FUNERAL DIRECTOR George J. Gonce F.H. 4001 Ritchie Hwy		25a. DATE REC'D. BY REGISTRAR JUN 4 1984		25b. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>				

RECORDED BY
SAC - FBI - PHILADELPHIA
ON JUNE 10, 1968
AT THE REQUEST OF
THE FEDERAL BUREAU OF INVESTIGATION,
U.S. DEPARTMENT OF JUSTICE
AND THE PHILADELPHIA POLICE
DEPARTMENT.
THIS TAPE WAS MADE FOR THE PURPOSE OF
MAINTAINING A RECORD OF THE CONVERSATION
HELD ON JUNE 10, 1968, BETWEEN THE
FEDERAL BUREAU OF INVESTIGATION AND THE
PHILADELPHIA POLICE DEPARTMENT.
IT IS THE PROPERTY OF THE FEDERAL BUREAU OF
INVESTIGATION AND IS TO BE RETURNED TO
THE FEDERAL BUREAU OF INVESTIGATION
AS SOON AS IT IS NO LONGER NEEDED.
IT IS NOT TO BE USED FOR ANY OTHER
PURPOSE THAN THAT FOR WHICH IT WAS
MADE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST SELMA		MIDDLE	LAST ZERIVITZ		06 09 84			4:31 A M					
Selma						Zerivitz										
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE			WHITE		MONTH 7 DAY 15 YEAR 20			63 000 YRS			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH City BALTIMORE MD.								
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Siuci Hospital		12a. USUAL OCCUPATION CLERK			12b. KIND OF BUSINESS OR INDUSTRY PARISERS BAKERY								
13a. STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 7 Slade Ave Apt 517 #21208					
14. FATHER'S NAME SAMUEL			MIDDLE M.	LAST GOLD	15. MOTHER'S MAIDEN NAME MARY			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-07-1336			17. INFORMANT BERYL ZERIVITZ ADDRESS 7 SLADE AVE., APT. 517 #21208		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma of Breast years 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) { DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 84 , to 6/9 , 19 84 , that (I) (we) last saw the deceased alive on 4/9 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Schultz</i>			DEGREE					22c. DATE SIGNED 6/9/84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCHULTZ, MICHAEL J.			22e. ADDRESS Suite 14 2435 W. Belvedere Ave 21215			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-10-84		23c. NAME OF CEMETERY OR CREMATORIAL BNAI ISRAEL CONG.			23d. LOCATION CITY OR TOWN BALTIMORE			COUNTY		STATE			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR JUN 14 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendell</i>										

Wesleyan's Curriculum of General Areas

107 P10 102 0103 1010 -

Gordon

SCYNS MICHELLE A 3602 103128 3125

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN 1 PAGE 5 FOR YOUR FILES.
AFTER DEATH: WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR		DE MEDIC/		OF MARYLAND DEPT. OF HEALTH AND MENTAL HYGIENE		8	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		LAST		REG. NO. 16	
Bessie				Zickler			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		7 1 06		77 yrs.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		10. DATE KNOWN OF ESTIMATE DEATH MATED	
U.S.		U.S.				6/16/84 19	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		3934 Norfolk Ave.				Baltimore City	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						13e. STREET ADDRESS 3934 Norfolk Ave.	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST		LAST	
Unkn.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Unkn.		212-34-3973		Lois Gentry		883 S. Military W. Palm Beach, Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>G. R. Kauffman</i>							
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER							
DATE SIGNED 6/17/84							
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6/27/84		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR Jul 2 1984		25b. REGISTRAR'S SIGNATURE <i>J. L. Kauffman, Jr.</i>	
Anatomy Board		Balto., Md.					
DHMH - 17 (VR A15 ME (5)) 20M 4/B2							

